

AMENDMENT TO H.R. 9393
OFFERED BY M____.

Add at the end the following new sections:

1 **SEC. 7. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
2 **VIDERS.**

3 (a) ERISA AMENDMENTS.—

4 (1) IN GENERAL.—Subpart B of part 7 of sub-
5 title B of the Employee Retirement Income Security
6 Act of 1974 (29 U.S.C. 1021 et seq.) is amended by
7 adding at the end the following:

8 **“SEC. 727. OVERSIGHT OF ADMINISTRATIVE SERVICE PRO-**
9 **VIDERS.**

10 “(a) IN GENERAL.—For plan years beginning on or
11 after the date that is 2 years after the date of enactment
12 of this section, no agreement between a group health plan
13 (as defined in section 733(a)), the plan sponsor of such
14 plan (as defined in section 3(16)(B)), the plan adminis-
15 trator of such plan (as defined in section 3(16)(A)), or
16 a business associate of such plan (as defined in section
17 160.103 of title 45, Code of Federal Regulations), (or
18 health insurance issuer offering group health insurance
19 coverage in connection with such a plan), and a health
20 care provider, network or association of providers, third-

1 party administrator, service provider offering access to a
2 network of providers, pharmacy benefit managers, or any
3 other third party (each referred to as a ‘health plan service
4 provider’) is permissible if such agreement limits (or
5 delays beyond the applicable reporting period described in
6 subsection (b)(1)) the disclosure of information to group
7 health plans in such a manner that prevents such plan,
8 issuer, or entity from providing the information described
9 in subsection (b).

10 “(b) REQUIRED DISCLOSURES.—

11 “(1) CONTENTS AND FREQUENCY.—With re-
12 spect to plan years beginning on or after the date
13 that is 2 years after the date of enactment of this
14 section, not less frequently than quarterly, a health
15 plan service provider shall provide to the group
16 health plan or health insurance issuer the following
17 information at no cost to the group health plan or
18 health insurance issuer:

19 “(A) The information described in section
20 724(a)(1)(B).

21 “(B) Any contractual and subcontractual
22 calculation methodologies, pricing or fee sched-
23 ules, or other formulae used to determine reim-
24 bursement amounts to providers and sub-
25 contractors, including methodologies, schedules,

1 fee structures, and any applied adjustments or
2 modifiers, with such information provided in a
3 manner sufficiently detailed to enable the group
4 health plan or health insurance issuer to accu-
5 rately assess, verify, and ensure compliance
6 with the terms of any contractual and sub-
7 contractual agreement governing the reimburse-
8 ment amounts.

9 “(C) The total amount received or ex-
10 pected to be received by the health plan service
11 provider or its subcontractors in provider or
12 supplier rebates, fees, alternative discounts, and
13 all other remuneration including amounts held
14 in escrow or variance accounts that has been
15 paid or is to be paid for claims incurred and
16 administrative services including data sales or
17 network payments.

18 “(D) The total amount paid or expected to
19 be paid by the health plan service provider or
20 to subcontractors in rebates, fees, contractual
21 arrangements, and all other remuneration that
22 has been paid or is expected to be paid for ad-
23 ministrative and other services.

24 “(E) All payment data and reconciliation
25 information related to alternative compensation

1 arrangements including accountable care orga-
2 nizations, value-based programs, shared savings
3 programs, incentive compensation, bundled pay-
4 ments, capitation arrangements, performance
5 payments, and any other reimbursement or pay-
6 ment models, where the group health plan or
7 health insurance issuer paid fees, incurred obli-
8 gations, or made payments in connection with
9 the group health plan related to such arrange-
10 ments.

11 “(2) PRIVACY REQUIREMENTS.—

12 “(A) IN GENERAL.—Health plan service
13 providers shall provide the information or data
14 under paragraph (1) consistent with the pri-
15 vacy, security, and breach notification regula-
16 tions at parts 160 and 164 of title 45, Code of
17 Federal Regulations, promulgated under sub-
18 title F of the Health Insurance Portability and
19 Accountability Act of 1996, subtitle D of the
20 Health Information Technology for Clinical
21 Health Act of 2009, and section 1180 of the
22 Social Security Act, and shall restrict the use
23 and disclosure of such information according to
24 such privacy, security, and breach notification
25 regulations. An entity that receives a disclosure

1 from a party in interest pursuant to subpara-
2 graph (B) or (C) shall comply with the privacy
3 and security regulations promulgated under
4 HIPAA.

5 “(B) RESTRICTIONS.—A group health plan
6 shall comply with section 164.504(f) of title 45,
7 Code of Federal Regulations (or a successor
8 regulation), and a plan sponsor shall act in ac-
9 cordance with the terms of the agreement de-
10 scribed in such section.

11 “(C) RULE OF CONSTRUCTION.—Nothing
12 in this section shall be construed to modify the
13 requirements for the creation, receipt, mainte-
14 nance, or transmission of protected health in-
15 formation under the HIPAA privacy regulations
16 (45 C.F.R. parts 160 and 164, subparts A and
17 E).

18 “(3) DISCLOSURE AND REDISCLOSURE.—

19 “(A) IN GENERAL.—A group health plan
20 receiving information under paragraph (1) may
21 disclose such information only—

22 “(i) to the entity from which the in-
23 formation was received or to that entity’s
24 business associates or to the group health
25 plan’s business associates as defined in

1 section 160.103 of title 45, Code of Fed-
2 eral Regulations (or successor regulations);
3 or

4 “(ii) as permitted by the HIPAA Pri-
5 vacy Rule (45 C.F.R. parts 160 and 164,
6 subparts A and E).

7 “(B) AVAILABILITY OF INFORMATION.—To
8 the extent the information required by this sub-
9 section is made available to the health insur-
10 ance issuer offering group health insurance in
11 connection with a group health plan, the health
12 insurance issuer shall make such information
13 available, at the same time, in the same format,
14 and at no cost, to the group health plan.

15 “(C) FAILURE TO PROVIDE.—The obliga-
16 tion to provide information pursuant to this
17 subsection shall exist notwithstanding the pres-
18 ence of any formal data-sharing agreement be-
19 tween the parties. Failure to provide the re-
20 quired information as specified shall constitute
21 a violation of this Act and the Secretary shall
22 initiate enforcement action under section 502
23 within 90 days of becoming aware of a violation
24 of this section, except that nothing in this sec-

1 tion shall be construed to limit the Secretary's
2 existing authority under the Act.

3 “(4) DATA FORMAT STANDARDS.—All data and
4 information provided pursuant to this subsection
5 shall comply with the following standards:

6 “(A) All claims from a healthcare provider
7 shall be made to the group health plan in ac-
8 cordance with transactions standards adopted
9 under HIPAA, as follows:

10 “(i) Institutional, professional, and
11 dental claims and adjustments to these
12 claims shall be in ASC X12N 837 format,
13 as transmitted by the provider, or, in the
14 case of paper claims, converted to the ASC
15 X12N 837 electronic format.

16 “(ii) Prescription drug claims shall be
17 in the National Council for Prescription
18 Drug Programs (NCPDP) format, as
19 transmitted by the provider, or in the case
20 of paper claims, converted to the NCPDP
21 electronic format.

22 “(iii) Such data shall be provided at
23 no cost to the group health plan.

24 “(B) All claim payment (or EFT, elec-
25 tronic funds transfer) and electronic remittance

1 advice (ERA) information sent by a health plan
2 service provider shall be provided to the group
3 health plan or health insurance issuer in the
4 ASC X12N 835 format in accordance with
5 transaction standards adopted under HIPAA,
6 unmodified from the form in which it was
7 transmitted to the healthcare provider. Such in-
8 formation shall be provided at no cost to the
9 group health plan or health insurance issuer.

10 “(C) The Secretary may modify the stand-
11 ards set forth in this paragraph as necessary to
12 align with any changes adopted by the Sec-
13 retary of Health and Human Services pursuant
14 to the authority provided under section 1173 of
15 the Social Security Act (42 U.S.C. 1320d–2).

16 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
17 provision in an agreement between a group health plan,
18 the plan sponsor, the plan administrator, or a business
19 associate of such plan or a health insurance issuer and
20 a health plan service provider that unduly delays or limits
21 a group health plan’s or health insurance issuer’s access
22 to information described in this section or that restricts
23 the format or timing of the provision of such information
24 in a manner that is inconsistent with the requirements of
25 this section shall be prohibited and, if a group health plan

1 or health insurance issuer enters into such agreement,
2 shall be deemed void as against public policy.

3 “(d) PENALTIES FOR NON-COMPLIANCE.—Any fail-
4 ure by a health plan service provider to comply with the
5 requirements of this section shall result in the imposition
6 of a civil penalty of \$100,000 for each day the violation
7 continues, in addition to any other penalties prescribed by
8 law.

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

13 (2) PENALTY.—

14 (A) IN GENERAL.—Section 502(a) of the
15 Employee Retirement Income Security Act of
16 1974 (29 U.S.C. 1132(a)) is amended by add-
17 ing at the end the following new paragraph:

18 “(14) The Secretary may assess a civil penalty
19 against any person of \$100,000 per day for each vio-
20 lation by any person of section 726.”.

21 (B) TECHNICAL AMENDMENT.—Paragraph
22 (6) of section 502(a) of the Employee Retirement
23 Income Security Act of 1974 (29 U.S.C.
24 1132(a)) is amended by striking “or (9)” and

1 inserting it with the phrase “(9), (13), or
2 (14)”.

3 (b) PHSA AMENDMENTS.—

4 (1) IN GENERAL.—Part D of title XXVII of the
5 Public Health Service Act (42 U.S.C. 300gg–111 et
6 seq.) is amended by adding at the end the following:

7 **“SEC. 2799A–12. OVERSIGHT OF ADMINISTRATIVE SERVICE**
8 **PROVIDERS.**

9 “(a) IN GENERAL.—For plan years beginning on or
10 after the date that is 1 year after the date of enactment
11 of this section, no agreement between a group health plan
12 that is a self-funded, non-Federal governmental plan, as
13 defined in section 2791(d)(8)(C) (42 U.S.C. 300gg–
14 91(d)(8)(C)), and a health care provider, network or asso-
15 ciation of providers, third-party administrator, service pro-
16 vider offering access to a network of providers, pharmacy
17 benefit managers, or any other third party (each referred
18 to in this section as a ‘health plan service provider’) is
19 permissible if such agreement limits (or delays beyond the
20 applicable reporting period described in subsection (b)(1))
21 the disclosure of information to group health plans in such
22 a manner that prevents such plan, issuer, or entity from
23 providing the information described in subsection (b).

24 “(b) REQUIRED DISCLOSURES.—

1 “(1) CONTENTS AND FREQUENCY.—With re-
2 spect to plan years beginning on or after the date
3 that is 1 year after the date of enactment of this
4 section, not less frequently than quarterly, a health
5 plan service provider shall provide to the group
6 health plan that is a self-funded, non-Federal gov-
7 ernmental plan the following information at no cost
8 to the plan:

9 “(A) The information described in section
10 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
11 119(a)(1)(B)).

12 “(B) Any contractual and subcontractual
13 calculation methodologies, pricing or fee sched-
14 ules, or other formulae used to determine reim-
15 bursement amounts to providers and sub-
16 contractors, including methodologies, schedules,
17 fee structures, and any applied adjustments or
18 modifiers, with such information provided in a
19 manner sufficiently detailed to enable the group
20 health plan to accurately assess, verify, and en-
21 sure compliance with the terms of any contrac-
22 tual and subcontractual agreement governing
23 the reimbursement amounts.

24 “(C) The total amount received or ex-
25 pected to be received by the health plan service

1 provider or its subcontractors in provider or
2 supplier rebates, fees, alternative discounts, and
3 all other remuneration including amounts held
4 in escrow or variance accounts that has been
5 paid or is to be paid for claims incurred and
6 administrative services including data sales or
7 network payments.

8 “(D) The total amount paid or expected to
9 be paid by the health plan service provider or
10 to subcontractors in rebates, fees, contractual
11 arrangements, and all other remuneration that
12 has been paid or is expected to be paid for ad-
13 ministrative and other services.

14 “(E) All payment data and reconciliation
15 information related to alternative compensation
16 arrangements including accountable care orga-
17 nizations, value-based programs, shared savings
18 programs, incentive compensation, bundled pay-
19 ments, capitation arrangements, performance
20 payments, and any other reimbursement or pay-
21 ment models, where the group health plan paid
22 fees, incurred obligations, or made payments in
23 connection with the group health plan related to
24 such arrangements.

25 “(2) PRIVACY REQUIREMENTS.—

1 “(A) IN GENERAL.—Health plan service
2 providers shall provide the information or data
3 under paragraph (1) consistent with the pri-
4 vacy, security, and breach notification regula-
5 tions at parts 160 and 164 of title 45, Code of
6 Federal Regulations, promulgated under sub-
7 title F of the Health Insurance Portability and
8 Accountability Act of 1996, subtitle D of the
9 Health Information Technology for Clinical
10 Health Act of 2009, and section 1180 of the
11 Social Security Act, and shall restrict the use
12 and disclosure of such information according to
13 such privacy, security, and breach notification
14 regulations. An entity that receives a disclosure
15 from a party in interest pursuant to subpara-
16 graph (B) or (C) shall comply with the privacy
17 and security regulations promulgated under
18 HIPAA.

19 “(B) RESTRICTIONS.—A group health plan
20 that is a self-funded, non-Federal governmental
21 plan shall comply with section 164.504(f) of
22 title 45, Code of Federal Regulations (or a suc-
23 cessor regulation), and a plan sponsor shall act
24 in accordance with the terms of the agreement
25 described in such section.

1 “(C) RULE OF CONSTRUCTION.—Nothing
2 in this section shall be construed to modify the
3 requirements for the creation, receipt, mainte-
4 nance, or transmission of protected health in-
5 formation under the HIPAA privacy regulations
6 (45 C.F.R. parts 160 and 164, subparts A and
7 E).

8 “(3) DISCLOSURE AND REDISCLOSURE.—

9 “(A) IN GENERAL.—A group health plan
10 that is a self-funded, non-Federal governmental
11 plan receiving information under paragraph (1)
12 may disclose such information only—

13 “(i) to the entity from which the in-
14 formation was received or to that entity’s
15 business associates as defined in section
16 160.103 of title 45, Code of Federal Regu-
17 lations (or successor regulations); or

18 “(ii) as permitted by the HIPAA Pri-
19 vacy Rule (45 C.F.R. parts 160 and 164,
20 subparts A and E).

21 “(B) RULE OF CONSTRUCTION.—Nothing
22 in this section shall be construed to prevent a
23 group health plan that is a self-funded, non-
24 Federal governmental plan, or a health plan
25 service provider providing services with respect

1 to such a plan, from placing reasonable restric-
2 tions on the public disclosure of the information
3 described in paragraph (1), except that such
4 plan or entity may not restrict disclosure of
5 such information to the Department of Health
6 and Human Services, the Department of Labor,
7 the Department of the Treasury, or the Comp-
8 troller General of the United States.

9 “(C) FAILURE TO PROVIDE.—The obliga-
10 tion to provide information pursuant to this
11 subsection shall exist notwithstanding the pres-
12 ence of any formal data-sharing agreement be-
13 tween the parties. Failure to provide the re-
14 quired information as specified shall constitute
15 a violation of this Act and the Secretary shall
16 initiate enforcement action under section
17 2723(b) (42 U.S.C. 300gg–22(b)) within 90
18 days of becoming aware of a violation of this
19 section, except that nothing in this section shall
20 be construed to limit the Secretary’s existing
21 authority under this Act.

22 “(4) DATA FORMAT STANDARDS.—All data and
23 information provided pursuant to this subsection
24 shall comply with the following standards:

1 “(A) All claims from a healthcare provider
2 shall be made to the group health plan in ac-
3 cordance with standards adopted under HIPAA
4 at section 162.1101 of title 45, Code of Federal
5 Regulations, as follows:

6 “(i) Institutional, professional, and
7 dental claims and adjustments to these
8 claims shall be provided to the group
9 health plan that is a self-funded, non-Fed-
10 eral governmental plan in the ASC X12N
11 837 format.

12 “(ii) Prescription drug claims shall be
13 in the National Council for Prescription
14 Drug Programs (NCPDP) format.

15 “(iii) The files shall be unmodified
16 copies of the files sent from the provider.
17 In the event that paper claims are sent by
18 the provider, they shall be converted to the
19 appropriate standard electronic format.
20 Such data shall be provided at no cost to
21 the group health plan.

22 “(B) All claim payment (or EFT, elec-
23 tronic funds transfer) and electronic remittance
24 advice (ERA) information sent by a health plan
25 service provider shall be provided to the group

1 health plan or health insurance issuer in the
2 ASC X12N 835 format, in accordance with
3 standards adopted under HIPAA at section
4 162.1602 of title 45, Code of Federal Regula-
5 tions, unmodified from the form in which it was
6 transmitted to the healthcare provider. Such in-
7 formation shall be provided at no cost to the
8 group health plan.

9 “(C) The Secretary may modify the stand-
10 ards set forth in this paragraph as necessary to
11 align with any changes adopted by the Sec-
12 retary pursuant to the authority provided under
13 section 1173 of the Social Security Act (42
14 U.S.C. 1320d–2).

15 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
16 provision in an agreement that unduly delays or limits a
17 group health plan that is a self-funded, non-Federal gov-
18 ernmental plan’s access to information described in this
19 section or that restricts the format or timing of the provi-
20 sion of such information in a manner that is inconsistent
21 with the requirements of this section shall be prohibited
22 and, if a self-funded, non-Federal governmental plan en-
23 ters into such agreement, shall be deemed void as against
24 public policy.

1 “(d) 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 (2) PENALTY.—Section 2723(b) of the Public
6 Health Service Act (42 U.S.C. 300gg–22(b)) is
7 amended by adding at the end the following:

8 “(4) ENFORCEMENT AUTHORITY RELATING TO
9 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
10 standing any provisions to the contrary, the Sec-
11 retary may assess a penalty against a health plan
12 service provider, as defined in section 2799A–12(a)
13 (42 U.S.C. 300gg–121(a)), of \$100,000 per day for
14 each violation of such section, pursuant to substan-
15 tially similar processes and procedures as those set
16 forth in section 2723(b)(2)(D) through (G) (42
17 U.S.C. 300gg–121(b)(2)(D) through (G)).”.

18 **SEC. 8. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

19 (a) PHSA AMENDMENTS.—

20 (1) EMERGENCY SERVICES.—Section 2799A–
21 1(f)(1)(C) of the Public Health Service Act (42
22 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
23 follows:

24 “(C) A good faith estimate of the amount
25 the plan or coverage is responsible for paying

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

8 (2) EXPLANATION OF BENEFITS.—Section
9 2799A–1 of the Public Health Service Act (42
10 U.S.C. 300gg–111) is amended by adding at the end
11 the following:

12 “(g) EXPLANATION OF BENEFITS.—

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

1 “(A) Whether or not the provider or facil-
2 ity is a participating provider or a participating
3 facility with respect to the plan or coverage
4 with respect to the furnishing of such item or
5 service.

6 “(B) An itemized explanation of benefits
7 that includes the following:

8 “(i) A plain language description of
9 each item or service.

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

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

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

21 “(v) The amount that the participant,
22 beneficiary, or enrollee has incurred toward
23 meeting the limit of the financial responsi-
24 bility (including with respect to deductibles
25 and out-of-pocket maximums) under the

1 plan or coverage (as of the date of such
2 notification).

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

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

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

14 (b) IRC AMENDMENTS.—

15 (1) EMERGENCY SERVICES.—Section
16 9816(f)(1)(C) of the Internal Revenue Code of 1986
17 is amended to read as follows:

18 “(C) A good faith estimate of the amount
19 the plan is responsible for paying for items and
20 services included in the estimate described in
21 subparagraph (B), including a plain language
22 description of each item or service and all appli-
23 cable billing codes for each item or service, in-
24 cluding modifiers, using standard and com-

1 monly recognized billing code sets that are
2 clearly identified.”.

3 (2) EXPLANATION OF BENEFITS.—Section
4 9816 of the Internal Revenue Code of 1986 is
5 amended by adding at the end the following:

6 “(g) EXPLANATION OF BENEFITS.—

7 “(1) IN GENERAL.—For plan years beginning
8 on or after January 1, 2026, each group health plan
9 shall, within 45 days of receiving any request for
10 payment for an item or service under the plan, pro-
11 vide to the participant or beneficiary (through mail
12 or electronic means, as requested by the participant
13 or beneficiary) a notification (in clear and under-
14 standable language and utilizing substantially the
15 same format as the advanced explanation of benefits
16 required by subsection (f) to enable comparison) in-
17 cluding the following:

18 “(A) Whether or not the provider or facil-
19 ity is a participating provider or a participating
20 facility with respect to the plan with respect to
21 the furnishing of such item or 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 is respon-
6 sible for paying for each item or service.

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

11 “(v) The amount that the participant
12 or beneficiary has incurred toward meeting
13 the limit of the financial responsibility (in-
14 cluding with respect to deductibles and
15 out-of-pocket maximums) under the plan
16 (as of the date of such notification).

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

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

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

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

3 (c) ERISA AMENDMENTS.—

4 (1) EMERGENCY SERVICES.—Section
5 716(f)(1)(C) of the Employee Retirement Income
6 Security Act of 1974 (29 U.S.C. 1185e(f)(1)(C)) is
7 amended to read as follows:

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

17 (2) EXPLANATION OF BENEFITS.—Section 716
18 of the Employee Retirement Income Security Act of
19 1974 (29 U.S.C. 1185e) is amended by adding at
20 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 or health insurance issuer offering group health in-
25 surance coverage shall, within 45 days of receiving

1 any request for payment for an item or service
2 under the plan, provide to the participant or bene-
3 ficiary (through mail or electronic means, as re-
4 quested by the participant or beneficiary) a notifica-
5 tion (in clear and understandable language and uti-
6 lizing substantially the same format as the advanced
7 explanation of benefits required by subsection (f) to
8 enable comparison) including the following:

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

14 “(B) An itemized explanation of benefits
15 that includes the following:

16 “(i) A plain language description of
17 each item or service.

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

22 “(iii) The amount the plan or cov-
23 erage is responsible for paying for each
24 item or service.

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

5 “(v) The amount that the participant
6 or beneficiary has incurred toward meeting
7 the limit of the financial responsibility (in-
8 cluding with respect to deductibles and
9 out-of-pocket maximums) under the plan
10 or coverage (as of the date of such notifi-
11 cation).

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

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

18 “(h) **REGULATIONS.**—The Secretary shall implement
19 this section through notice and comment rulemaking in
20 accordance with section 553 of title 5, United States
21 Code.”.

22 **SEC. 9. PROVISION OF ITEMIZED BILLS.**

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

1 **“SEC. 2799B-10. PROVIDER REQUIREMENTS FOR ITEMIZED**
2 **BILLS.**

3 “(a) REQUIREMENTS.—

4 “(1) ITEMIZED BILL AND OTHER INFORMATION
5 REQUIRED.—

6 “(A) IN GENERAL.—A health care provider
7 or health care facility that requests payment
8 from an individual after providing a health care
9 item or service to the patient shall include with
10 such request a written, itemized bill of the cost
11 of each reasonably expected item or service the
12 health care provider or health care facility pro-
13 vided to the individual, including telehealth vis-
14 its or visits by other electronic means. The
15 health care provider or health care facility shall
16 provide the itemized bill not later than 30 days
17 after the health care provider or health care fa-
18 cility received a final payment on the provided
19 service or supply from a third party.

20 “(B) REQUIRED INFORMATION.—For each
21 item or service provided by the health care pro-
22 vider or facility or for which the health care
23 provider or facility is billing the individual, the
24 itemized bill must include—

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

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

6 “(iii) the price and billed amount, if
7 different, of each distinct health care item
8 or service or if the provider or facility is
9 offering binding, all-in prices for bundled
10 items and services, the total binding price
11 for bundled items and services and billed
12 amount;

13 “(iv) any payments made to the
14 health care provider or health care facility
15 by or on behalf of the individual (including
16 payments by any health plan or insurance)
17 for any health care item or service covered
18 in the itemized bill;

19 “(v) information about the availability
20 of language-assistance services for individ-
21 uals with limited English proficiency
22 (LEP);

23 “(vi) the identification of an office or
24 individual at the health care provider or
25 health care facility, including phone num-

1 ber and email address, that shall be able to
2 discuss the specific details of the itemized
3 statement and be authorized to make ap-
4 propriate changes thereto; and

5 “(vii) information about the health
6 care provider’s or health care facility’s
7 charity care policies and instructions on
8 how to apply for charity care.

9 “(2) COLLECTIONS ACTIONS.—

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

13 “(i) for any provided health care item
14 or service unless the health care provider
15 or health care facility has complied with
16 paragraph (1); or

17 “(ii) with respect to any items or serv-
18 ices for which the amount appearing on an
19 itemized bill described above in paragraph
20 (1) exceeds the amount disclosed pursuant
21 to Federal health care price transparency
22 regulations, including part 180 of title 45,
23 Code of Federal Regulations, or provided
24 in a good faith estimate that complies with
25 section 2799B–6 of this Act and section

1 149.610 of title 45, Code of Federal Regu-
2 lations, or another good faith estimate pro-
3 vided by a health care entity covered under
4 this section but not otherwise covered
5 under such section 2799B–6 unless the
6 provider or facility documents that the ad-
7 ditional items or services were medically
8 necessary due to unforeseen complications
9 or a patient-initiated change, and could not
10 reasonably have been anticipated.

11 “(B) BURDEN OF PROOF.—The burden of
12 proof under subparagraph (A)(ii) shall rest with
13 the provider, and absent the documentation de-
14 scribed in such subparagraph, the good faith es-
15 timate shall be binding.

16 “(b) FAILURE TO COMPLY.—

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

22 “(2) PRESUMPTION IN FAVOR OF INDIVIDUAL.—If a health care provider or health care fa-
23 cility fails to comply with the requirements of this
24 section, the presumption shall be that charges were
25

1 substantially in excess of the good faith estimate (as
2 set forth in section 2799B–6) for the purpose of any
3 patient-provider dispute, including in accordance
4 with section 2799B–7 and regulations promulgated
5 thereunder.

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

