AMENDMENT TO H.R. 9393

OFFERED BY M__. _____

Add at the end the following new sections:

SEC. 7. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

(a) ERISA AMENDMENTS.—

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

"SEC. 727. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

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

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

''(b) REQUIRED DISCLOSURES.—

''(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 2 years after the date of enactment of this section, not less frequently than quarterly, a health plan service provider shall provide to the group health plan or health insurance issuer the following information at no cost to the group health plan or health insurance issuer:

''(A) The information described in section 724(a)(1)(B).

''(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules,

fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan or health insurance issuer to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

''(C) The total amount received or expected to be received by the health plan service provider or its subcontractors in provider or supplier rebates, fees, alternative discounts, and all other remuneration including amounts held in escrow or variance accounts that has been paid or is to be paid for claims incurred and administrative services including data sales or network payments.

''(D) The total amount paid or expected to be paid by the health plan service provider or to subcontractors in rebates, fees, contractual arrangements, and all other remuneration that has been paid or is expected to be paid for administrative and other services.

''(E) All payment data and reconciliation information related to alternative compensation

arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan or health insurance issuer paid fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—Health plan service providers shall provide the information or data under paragraph (1) consistent with the privacy, security, and breach notification regulations at parts 160 and 164 of title 45, Code of Federal Regulations, promulgated under subtitle F of the Health Insurance Portability and Accountability Act of 1996, subtitle D of the Health Information Technology for Clinical Health Act of 2009, and section 1180 of the Social Security Act, and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations. An entity that receives a disclosure

from a party in interest pursuant to subparagraph (B) or (C) shall comply with the privacy and security regulations promulgated under HIPAA.

''(B) RESTRICTIONS.—A group health plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (45 C.F.R. parts 160 and 164, subparts A and E).

''(3) DISCLOSURE AND REDISCLOSURE.—

''(A) IN GENERAL.—A group health plan receiving information under paragraph (1) may disclose such information only—

''(i) to the entity from which the information was received or to that entity's business associates or to the group health plan's business associates as defined in

section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

''(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, subparts A and E).

''(B) AVAILABILITY OF INFORMATION.—To the extent the information required by this subsection is made available to the health insurance issuer offering group health insurance in connection with a group health plan, the health insurance issuer shall make such information available, at the same time, in the same format, and at no cost, to the group health plan.

''(C) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 502 within 90 days of becoming aware of a violation of this section, except that nothing in this sec-

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

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

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with transactions standards adopted under HIPAA, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be in ASC X12N 837 format, as transmitted by the provider, or, in the case of paper claims, converted to the ASC X12N 837 electronic format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format, as transmitted by the provider, or in the case of paper claims, converted to the NCPDP electronic format.

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

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance

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

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary of Health and Human Services pursuant to the authority provided under section 1173 of the Social Security Act (42 U.S.C. 1320d–2).

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

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

''(d) PENALTIES FOR NON-COMPLIANCE.—Any failure by a health plan service provider to comply with the requirements of this section shall result in the imposition of a civil penalty of $100,000 for each day the violation continues, in addition to any other penalties prescribed by law.

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

(2) PENALTY.—

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

''(14) The Secretary may assess a civil penalty against any person of $100,000 per day for each violation by any person of section 726.''.

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

inserting it with the phrase ''(9), (13), or (14)''.

(b) PHSA AMENDMENTS.—

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

''SEC. 2799A–12. OVERSIGHT OF ADMINISTRATIVE SERVICE PROVIDERS.

''(a) IN GENERAL.—For plan years beginning on or after the date that is 1 year after the date of enactment of this section, no agreement between a group health plan that is a self-funded, non-Federal governmental plan, as defined in section 2791(d)(8)(C) (42 U.S.C. 300gg–91(d)(8)(C)), and a health care provider, network or association of providers, third-party administrator, service provider offering access to a network of providers, pharmacy benefit managers, or any other third party (each referred to in this section as a 'health plan service provider') is permissible if such agreement limits (or delays beyond the applicable reporting period described in subsection (b)(1)) the disclosure of information to group health plans in such a manner that prevents such plan, issuer, or entity from providing the information described in subsection (b).

''(b) REQUIRED DISCLOSURES.—

"(1) CONTENTS AND FREQUENCY.—With respect to plan years beginning on or after the date that is 1 year after the date of enactment of this section, not less frequently than quarterly, a health plan service provider shall provide to the group health plan that is a self-funded, non-Federal governmental plan the following information at no cost to the plan:

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

"(B) Any contractual and subcontractual calculation methodologies, pricing or fee schedules, or other formulae used to determine reimbursement amounts to providers and subcontractors, including methodologies, schedules, fee structures, and any applied adjustments or modifiers, with such information provided in a manner sufficiently detailed to enable the group health plan to accurately assess, verify, and ensure compliance with the terms of any contractual and subcontractual agreement governing the reimbursement amounts.

"(C) The total amount received or expected to be received by the health plan service

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

''(D) The total amount paid or expected to be paid by the health plan service provider or to subcontractors in rebates, fees, contractual arrangements, and all other remuneration that has been paid or is expected to be paid for administrative and other services.

''(E) All payment data and reconciliation information related to alternative compensation arrangements including accountable care organizations, value-based programs, shared savings programs, incentive compensation, bundled payments, capitation arrangements, performance payments, and any other reimbursement or payment models, where the group health plan paid fees, incurred obligations, or made payments in connection with the group health plan related to such arrangements.

''(2) PRIVACY REQUIREMENTS.—

''(A) IN GENERAL.—Health plan service providers shall provide the information or data under paragraph (1) consistent with the privacy, security, and breach notification regulations at parts 160 and 164 of title 45, Code of Federal Regulations, promulgated under subtitle F of the Health Insurance Portability and Accountability Act of 1996, subtitle D of the Health Information Technology for Clinical Health Act of 2009, and section 1180 of the Social Security Act, and shall restrict the use and disclosure of such information according to such privacy, security, and breach notification regulations. An entity that receives a disclosure from a party in interest pursuant to subparagraph (B) or (C) shall comply with the privacy and security regulations promulgated under HIPAA.

''(B) RESTRICTIONS.—A group health plan that is a self-funded, non-Federal governmental plan shall comply with section 164.504(f) of title 45, Code of Federal Regulations (or a successor regulation), and a plan sponsor shall act in accordance with the terms of the agreement described in such section.

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the requirements for the creation, receipt, maintenance, or transmission of protected health information under the HIPAA privacy regulations (45 C.F.R. parts 160 and 164, subparts A and E).

''(3) DISCLOSURE AND REDISCLOSURE.—

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

''(i) to the entity from which the information was received or to that entity's business associates as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations); or

''(ii) as permitted by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, subparts A and E).

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

to such a plan, from placing reasonable restrictions on the public disclosure of the information described in paragraph (1), except that such plan or entity may not restrict disclosure of such information to the Department of Health and Human Services, the Department of Labor, the Department of the Treasury, or the Comptroller General of the United States.

''(C) FAILURE TO PROVIDE.—The obligation to provide information pursuant to this subsection shall exist notwithstanding the presence of any formal data-sharing agreement between the parties. Failure to provide the required information as specified shall constitute a violation of this Act and the Secretary shall initiate enforcement action under section 2723(b) (42 U.S.C. 300gg–22(b)) within 90 days of becoming aware of a violation of this section, except that nothing in this section shall be construed to limit the Secretary's existing authority under this Act.

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

''(A) All claims from a healthcare provider shall be made to the group health plan in accordance with standards adopted under HIPAA at section 162.1101 of title 45, Code of Federal Regulations, as follows:

''(i) Institutional, professional, and dental claims and adjustments to these claims shall be provided to the group health plan that is a self-funded, non-Federal governmental plan in the ASC X12N 837 format.

''(ii) Prescription drug claims shall be in the National Council for Prescription Drug Programs (NCPDP) format.

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

''(B) All claim payment (or EFT, electronic funds transfer) and electronic remittance advice (ERA) information sent by a health plan service provider shall be provided to the group

health plan or health insurance issuer in the ASC X12N 835 format, in accordance with standards adopted under HIPAA at section 162.1602 of title 45, Code of Federal Regulations, unmodified from the form in which it was transmitted to the healthcare provider. Such information shall be provided at no cost to the group health plan.

''(C) The Secretary may modify the standards set forth in this paragraph as necessary to align with any changes adopted by the Secretary pursuant to the authority provided under section 1173 of the Social Security Act (42 U.S.C. 1320d–2).

''(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any provision in an agreement that unduly delays or limits a group health plan that is a self-funded, non-Federal governmental plan's access to information described in this section or that restricts the format or timing of the provision of such information in a manner that is inconsistent with the requirements of this section shall be prohibited and, if a self-funded, non-Federal governmental plan enters into such agreement, shall be deemed void as against public policy.

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

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

''(4) ENFORCEMENT AUTHORITY RELATING TO HEALTH PLAN SERVICE PROVIDERS.—Notwithstanding any provisions to the contrary, the Secretary may assess a penalty against a health plan service provider, as defined in section 2799A–12(a) (42 U.S.C. 300gg–121(a)), of $100,000 per day for each violation of such section, pursuant to substantially similar processes and procedures as those set forth in section 2723(b)(2)(D) through (G) (42 U.S.C. 300gg–121(b)(2)(D) through (G)).''.

SEC. 8. 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 com-

monly 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, 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 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 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 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. 9. 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 num-

ber 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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