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(Original Signature of Member)

119TH CONGRESS
2D SESSION

H. R.

To promote the availability of ceratin health care information, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. LANGWORTHY introduced the following bill; which was referred to the Committee on _____

A BILL

To promote the availability of ceratin health care information, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Clear Healthcare Ex-
5 pense Cost Knowledge Act of 2026” or the “CHECK Act
6 of 2026”.

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

9 (a) ERISA AMENDMENTS.—

1 issuer, or entity from providing the information described
2 in subsection (b).

3 “(b) REQUIRED DISCLOSURES.—

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

12 “(A) The information described in section
13 724(a)(1)(B).

14 “(B) Any contractual and subcontractual
15 calculation methodologies, pricing or fee sched-
16 ules, or other formulae used to determine reim-
17 bursement amounts to providers and sub-
18 contractors, including methodologies, schedules,
19 fee structures, and any applied adjustments or
20 modifiers, with such information provided in a
21 manner sufficiently detailed to enable the group
22 health plan or health insurance issuer to accu-
23 rately assess, verify, and ensure compliance
24 with the terms of any contractual and sub-

1 contractual agreement governing the reimburse-
2 ment amounts.

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

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

18 “(E) All payment data and reconciliation
19 information related to alternative compensation
20 arrangements including accountable care orga-
21 nizations, value-based programs, shared savings
22 programs, incentive compensation, bundled pay-
23 ments, capitation arrangements, performance
24 payments, and any other reimbursement or pay-
25 ment models, where the group health plan or

1 health insurance issuer paid fees, incurred obli-
2 gations, or made payments in connection with
3 the group health plan related to such arrange-
4 ments.

5 “(2) PRIVACY REQUIREMENTS.—

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

24 “(B) RESTRICTIONS.—A group health plan
25 shall comply with section 164.504(f) of title 45,

1 Code of Federal Regulations (or a successor
2 regulation), and a plan sponsor shall act in ac-
3 cordance with the terms of the agreement de-
4 scribed in such section.

5 “(C) RULE OF CONSTRUCTION.—Nothing
6 in this section shall be construed to modify the
7 requirements for the creation, receipt, mainte-
8 nance, or transmission of protected health in-
9 formation under the HIPAA privacy regulations
10 (45 C.F.R. parts 160 and 164, subparts A and
11 E).

12 “(3) DISCLOSURE AND REDISCLOSURE.—

13 “(A) IN GENERAL.—A group health plan
14 receiving information under paragraph (1) may
15 disclose such information only—

16 “(i) to the entity from which the in-
17 formation was received or to that entity’s
18 business associates or to the group health
19 plan’s business associates as defined in
20 section 160.103 of title 45, Code of Fed-
21 eral Regulations (or successor regulations);
22 or

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

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

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 502
17 within 90 days of becoming aware of a violation
18 of this section, except that nothing in this sec-
19 tion shall be construed to limit the Secretary’s
20 existing authority under the Act.

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

24 “(A) All claims from a healthcare provider
25 shall be made to the group health plan in ac-

1 cordance with transactions standards adopted
2 under HIPAA, as follows:

3 “(i) Institutional, professional, and
4 dental claims and adjustments to these
5 claims shall be in ASC X12N 837 format,
6 as transmitted by the provider, or, in the
7 case of paper claims, converted to the ASC
8 X12N 837 electronic format.

9 “(ii) Prescription drug claims shall be
10 in the National Council for Prescription
11 Drug Programs (NCPDP) format, as
12 transmitted by the provider, or in the case
13 of paper claims, converted to the NCPDP
14 electronic format.

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

17 “(B) All claim payment (or EFT, elec-
18 tronic funds transfer) and electronic remittance
19 advice (ERA) information sent by a health plan
20 service provider shall be provided to the group
21 health plan or health insurance issuer in the
22 ASC X12N 835 format in accordance with
23 transaction standards adopted under HIPAA,
24 unmodified from the form in which it was
25 transmitted to the healthcare provider. Such in-

1 formation shall be provided at no cost to the
2 group health plan or health insurance issuer.

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

9 “(c) PROHIBITED CONTRACTUAL PROVISIONS.—Any
10 provision in an agreement between a group health plan,
11 the plan sponsor, the plan administrator, or a business
12 associate of such plan or a health insurance issuer and
13 a health plan service provider that unduly delays or limits
14 a group health plan’s or health insurance issuer’s access
15 to information described in this section or that restricts
16 the format or timing of the provision of such information
17 in a manner that is inconsistent with the requirements of
18 this section shall be prohibited and, if a group health plan
19 or health insurance issuer enters into such agreement,
20 shall be deemed void as against public policy.

21 “(d) PENALTIES FOR NON-COMPLIANCE.—Any fail-
22 ure by a health plan service provider to comply with the
23 requirements of this section shall result in the imposition
24 of a civil penalty of \$100,000 for each day the violation

1 continues, in addition to any other penalties prescribed by
2 law.

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

7 (2) PENALTY.—

8 (A) IN GENERAL.—Section 502(a) of the
9 Employee Retirement Income Security Act of
10 1974 (29 U.S.C. 1132(a)) is amended by add-
11 ing at the end the following new paragraph:

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

15 (B) TECHNICAL AMENDMENT.—Paragraph
16 (6) of section 502(a) of the Employee Retire-
17 ment Income Security Act of 1974 (29 U.S.C.
18 1132(a)) is amended by striking “or (9)” and
19 inserting it with the phrase “(9), (13), or
20 (14)”.

21 (b) PHSA AMENDMENTS.—

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

1 **“SEC. 2799A-12. OVERSIGHT OF ADMINISTRATIVE SERVICE**
2 **PROVIDERS.**

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

18 “(b) REQUIRED DISCLOSURES.—

19 “(1) CONTENTS AND FREQUENCY.—With re-
20 spect to plan years beginning on or after the date
21 that is 1 year after the date of enactment of this
22 section, not less frequently than quarterly, a health
23 plan service provider shall provide to the group
24 health plan that is a self-funded, non-Federal gov-
25 ernmental plan the following information at no cost
26 to the plan:

1 “(A) The information described in section
2 2799A–9(a)(1)(B) (42 U.S.C. 300gg–
3 119(a)(1)(B)).

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

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

1 “(D) The total amount paid or expected to
2 be paid by the health plan service provider or
3 to subcontractors in rebates, fees, contractual
4 arrangements, and all other remuneration that
5 has been paid or is expected to be paid for ad-
6 ministrative and other services.

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

18 “(2) PRIVACY REQUIREMENTS.—

19 “(A) IN GENERAL.—Health plan service
20 providers shall provide the information or data
21 under paragraph (1) consistent with the pri-
22 vacy, security, and breach notification regula-
23 tions at parts 160 and 164 of title 45, Code of
24 Federal Regulations, promulgated under sub-
25 title F of the Health Insurance Portability and

1 Accountability Act of 1996, subtitle D of the
2 Health Information Technology for Clinical
3 Health Act of 2009, and section 1180 of the
4 Social Security Act, and shall restrict the use
5 and disclosure of such information according to
6 such privacy, security, and breach notification
7 regulations. An entity that receives a disclosure
8 from a party in interest pursuant to subpara-
9 graph (B) or (C) shall comply with the privacy
10 and security regulations promulgated under
11 HIPAA.

12 “(B) RESTRICTIONS.—A group health plan
13 that is a self-funded, non-Federal governmental
14 plan shall comply with section 164.504(f) of
15 title 45, Code of Federal Regulations (or a suc-
16 cessor regulation), and a plan sponsor shall act
17 in accordance with the terms of the agreement
18 described in such section.

19 “(C) RULE OF CONSTRUCTION.—Nothing
20 in this section shall be construed to modify the
21 requirements for the creation, receipt, mainte-
22 nance, or transmission of protected health in-
23 formation under the HIPAA privacy regulations
24 (45 C.F.R. parts 160 and 164, subparts A and
25 E).

1 “(3) DISCLOSURE AND REDISCLOSURE.—

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

6 “(i) to the entity from which the in-
7 formation was received or to that entity’s
8 business associates as defined in section
9 160.103 of title 45, Code of Federal Regu-
10 lations (or successor regulations); or

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

14 “(B) RULE OF CONSTRUCTION.—Nothing
15 in this section shall be construed to prevent a
16 group health plan that is a self-funded, non-
17 Federal governmental plan, or a health plan
18 service provider providing services with respect
19 to such a plan, from placing reasonable restric-
20 tions on the public disclosure of the information
21 described in paragraph (1), except that such
22 plan or entity may not restrict disclosure of
23 such information to the Department of Health
24 and Human Services, the Department of Labor,

1 the Department of the Treasury, or the Comp-
2 troller General of the United States.

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

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

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

24 “(i) Institutional, professional, and
25 dental claims and adjustments to these

1 claims shall be provided to the group
2 health plan that is a self-funded, non-Fed-
3 eral governmental plan in the ASC X12N
4 837 format.

5 “(ii) Prescription drug claims shall be
6 in the National Council for Prescription
7 Drug Programs (NCPDP) format.

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

15 “(B) All claim payment (or EFT, elec-
16 tronic funds transfer) and electronic remittance
17 advice (ERA) information sent by a health plan
18 service provider shall be provided to the group
19 health plan or health insurance issuer in the
20 ASC X12N 835 format, in accordance with
21 standards adopted under HIPAA at section
22 162.1602 of title 45, Code of Federal Regula-
23 tions, unmodified from the form in which it was
24 transmitted to the healthcare provider. Such in-

1 formation shall be provided at no cost to the
2 group health plan.

3 “(C) The Secretary may modify the stand-
4 ards set forth in this paragraph as necessary to
5 align with any changes adopted by the Sec-
6 retary pursuant to the authority provided under
7 section 1173 of the Social Security Act (42
8 U.S.C. 1320d–2).

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

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

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

1 “(4) ENFORCEMENT AUTHORITY RELATING TO
2 HEALTH PLAN SERVICE PROVIDERS.—Notwith-
3 standing any provisions to the contrary, the Sec-
4 retary may assess a penalty against a health plan
5 service provider, as defined in section 2799A–12(a)
6 (42 U.S.C. 300gg–121(a)), of \$100,000 per day for
7 each violation of such section, pursuant to substan-
8 tially similar processes and procedures as those set
9 forth in section 2723(b)(2)(D) through (G) (42
10 U.S.C. 300gg–121(b)(2)(D) through (G)).”.

11 **SEC. 3. REQUIREMENT FOR EXPLANATION OF BENEFITS.**

12 (a) PHSA AMENDMENTS.—

13 (1) EMERGENCY SERVICES.—Section 2799A–
14 1(f)(1)(C) of the Public Health Service Act (42
15 U.S.C. 300gg–111(f)(1)(C)) is amended to read as
16 follows:

17 “(C) A good faith estimate of the amount
18 the plan or coverage is responsible for paying
19 for items and services included in the estimate
20 described in subparagraph (B), including a
21 plain language description of each item or serv-
22 ice and all applicable billing codes for each item
23 or service, including modifiers, using standard
24 and commonly recognized billing code sets that
25 are clearly identified.”.

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

5 “(g) EXPLANATION OF BENEFITS.—

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

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

24 “(B) An itemized explanation of benefits
25 that includes the following:

1 “(i) A plain language description of
2 each item or service.

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

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

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

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

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

22 “(2) FORMAT.—If applicable, the notification
23 described in paragraph (1) may be provided in con-
24 junction with, or as part of, a notice of a claim de-
25 termination or other communication required by sec-

1 tion 2719(a) (42 U.S.C. 300gg–19(a)), or regula-
2 tions thereunder.

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

7 (b) IRC AMENDMENTS.—

8 (1) EMERGENCY SERVICES.—Section
9 9816(f)(1)(C) of the Internal Revenue Code of 1986
10 is amended to read as follows:

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

20 (2) EXPLANATION OF BENEFITS.—Section
21 9816 of the Internal Revenue Code of 1986 is
22 amended by adding at the end the following:

23 “(g) EXPLANATION OF BENEFITS.—

24 “(1) IN GENERAL.—For plan years beginning
25 on or after January 1, 2026, each group health plan

1 shall, within 45 days of receiving any request for
2 payment for an item or service under the plan, pro-
3 vide to the participant or beneficiary (through mail
4 or electronic means, as requested by the participant
5 or beneficiary) a notification (in clear and under-
6 standable language and utilizing substantially the
7 same format as the advanced explanation of benefits
8 required by subsection (f) to enable comparison) in-
9 cluding the following:

10 “(A) Whether or not the provider or facil-
11 ity is a participating provider or a participating
12 facility with respect to the plan with respect to
13 the furnishing of such item or 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 is respon-
23 sible for paying for each item or service.

24 “(iv) The amount of any cost-sharing
25 for which the participant or beneficiary is

1 responsible for each item or service (as of
2 the date of such notification).

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

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

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

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

20 (c) ERISA AMENDMENTS.—

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

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

10 (2) EXPLANATION OF BENEFITS.—Section 716
11 of the Employee Retirement Income Security Act of
12 1974 (29 U.S.C. 1185e) is amended by adding at
13 the end the following:

14 “(g) EXPLANATION OF BENEFITS.—

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

1 explanation of benefits required by subsection (f) to
2 enable comparison) including the following:

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

8 “(B) An itemized explanation of benefits
9 that includes the following:

10 “(i) A plain language description of
11 each item or service.

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

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

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

23 “(v) The amount that the participant
24 or beneficiary has incurred toward meeting
25 the limit of the financial responsibility (in-

1 cluding with respect to deductibles and
2 out-of-pocket maximums) under the plan
3 or coverage (as of the date of such notifi-
4 cation).

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

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

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

15 **SEC. 4. PROVISION OF ITEMIZED BILLS.**

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

19 **“SEC. 2799B-10. PROVIDER REQUIREMENTS FOR ITEMIZED**
20 **BILLS.**

21 “(a) **REQUIREMENTS.**—

22 “(1) **ITEMIZED BILL AND OTHER INFORMATION**
23 **REQUIRED.**—

24 “(A) **IN GENERAL.**—A health care provider
25 or health care facility that requests payment

1 from an individual after providing a health care
2 item or service to the patient shall include with
3 such request a written, itemized bill of the cost
4 of each reasonably expected item or service the
5 health care provider or health care facility pro-
6 vided to the individual, including telehealth vis-
7 its or visits by other electronic means. The
8 health care provider or health care facility shall
9 provide the itemized bill not later than 30 days
10 after the health care provider or health care fa-
11 cility received a final payment on the provided
12 service or supply from a third party.

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

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

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

1 “(iii) the price and billed amount, if
2 different, of each distinct health care item
3 or service or if the provider or facility is
4 offering binding, all-in prices for bundled
5 items and services, the total binding price
6 for bundled items and services and billed
7 amount;

8 “(iv) any payments made to the
9 health care provider or health care facility
10 by or on behalf of the individual (including
11 payments by any health plan or insurance)
12 for any health care item or service covered
13 in the itemized bill;

14 “(v) information about the availability
15 of language-assistance services for individ-
16 uals with limited English proficiency
17 (LEP);

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

1 “(vii) information about the health
2 care provider’s or health care facility’s
3 charity care policies and instructions on
4 how to apply for charity care.

5 “(2) COLLECTIONS ACTIONS.—

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

9 “(i) for any provided health care item
10 or service unless the health care provider
11 or health care facility has complied with
12 paragraph (1); or

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

1 under such section 2799B–6 unless the
2 provider or facility documents that the ad-
3 ditional items or services were medically
4 necessary due to unforeseen complications
5 or a patient-initiated change, and could not
6 reasonably have been anticipated.

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

12 “(b) FAILURE TO COMPLY.—

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

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

1 with section 2799B–7 and regulations promulgated
2 thereunder.

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