ure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

**(g) Development of standard definitions**

**(1) In general**

The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

**(2) Insurance-related terms**

The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

**(3) Medical terms**

The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(July 1, 1944, ch. 373, title XXVII, §2715, as added and amended Pub. L. 111–148, title I, §1001(5), title X, §10101(b), Mar. 23, 2010, 124 Stat. 132, 884.)

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, §10101(b), substituted ''and providing to applicants, enrollees, and policyholders or certificate holders'' for ''and providing to enrollees''.

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

## § 300gg–15a. Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

(July 1, 1944, ch. 373, title XXVII, §2715A, as added Pub. L. 111–148, title X, §10101(c), Mar. 23, 2010, 124 Stat. 884.)

## § 300gg–16. Prohibition on discrimination in favor of highly compensated individuals

**(a) In general**

A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of title 26 (relating to prohibition on discrimination in favor of highly compensated individuals).

**(b) Rules and definitions**

For purposes of this section—

**(1) Certain rules to apply**

Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of title 26 shall apply.

**(2) Highly compensated individual**

The term ''highly compensated individual'' has the meaning given such term by section 105(h)(5) of title 26.

(July 1, 1944, ch. 373, title XXVII, §2716, as added and amended Pub. L. 111–148, title I, §1001(5), title X, §10101(d), Mar. 23, 2010, 124 Stat. 135, 884.)

AMENDMENTS

2010—Pub. L. 111–148, §10101(d), amended section generally. Prior to amendment, text read as follows:

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.''

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

## § 300gg–17. Ensuring the quality of care

**(a) Quality reporting**

**(1) In general**

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602[1] of the Patient Protection and

[1] See References in Text note below.

Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

**(2) Reporting requirements**

**(A) In general**

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

**(B) Timing of reports**

A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

**(C) Availability of reports**

The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

**(D) Penalties**

In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

**(E) Exceptions**

In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially meet the goals of this section.

**(b) Wellness and prevention programs**

For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

(1) Smoking cessation.
(2) Weight management.
(3) Stress management.
(4) Physical fitness.
(5) Nutrition.
(6) Heart disease prevention.
(7) Healthy lifestyle support.
(8) Diabetes prevention.

**(c) Protection of Second Amendment gun rights**

**(1) Wellness and prevention programs**

A wellness and health promotion activity implemented under subsection (a)(1)(D) may not require the disclosure or collection of any information relating to—

(A) the presence or storage of a lawfully-possessed firearm or ammunition in the residence or on the property of an individual; or

(B) the lawful use, possession, or storage of a firearm or ammunition by an individual.

**(2) Limitation on data collection**

None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used for the collection of any information relating to—

(A) the lawful ownership or possession of a firearm or ammunition;

(B) the lawful use of a firearm or ammunition; or

(C) the lawful storage of a firearm or ammunition.

**(3) Limitation on databases or data banks**

None of the authorities provided to the Secretary under the Patient Protection and Affordable Care Act or an amendment made by that Act shall be construed to authorize or may be used to maintain records of individual ownership or possession of a firearm or ammunition.

**(4) Limitation on determination of premium rates or eligibility for health insurance**

A premium rate may not be increased, health insurance coverage may not be denied, and a discount, rebate, or reward offered for participation in a wellness program may not be reduced or withheld under any health benefit plan issued pursuant to or in accordance with the Patient Protection and Affordable Care Act or an amendment made by that Act on the basis of, or on reliance upon—

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use or storage of a firearm or ammunition.

**(5) Limitation on data collection requirements for individuals**

No individual shall be required to disclose any information under any data collection activity authorized under the Patient Protection and Affordable Care Act or an amendment made by that Act relating to—

(A) the lawful ownership or possession of a firearm or ammunition; or

(B) the lawful use, possession, or storage of a firearm or ammunition.

**(d) Regulations**

Not later than 2 years after March 23, 2010, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

**(e) Study and report**

Not later than 180 days after the date on which regulations are promulgated under subsection

(c),[2] the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under this section have had on the quality and cost of health care.

(July 1, 1944, ch. 373, title XXVII, § 2717, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(e), Mar. 23, 2010, 124 Stat. 135, 884.)

REFERENCES IN TEXT

Section 3602 of the Patient Protection and Affordable Care Act, referred to in subsec. (a)(1)(A), is section 3602 of Pub. L. 111–148 which is set out as a note under section 1305w–21 of this title but the reference probably should be to section 3502 of the Act which is set out as a note under section 256a–1 of this title.

The Patient Protection and Affordable Care Act, referred to in subsec. (c), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

AMENDMENTS

2010—Subsecs. (c) to (e). Pub. L. 111–148, § 10101(e), added subsec. (c) and redesignated former subsecs. (c) and (d) as (d) and (e), respectively.

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

### § 300gg–18. Bringing down the cost of health care coverage

**(a) Clear accounting for costs**

A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

(1) on reimbursement for clinical services provided to enrollees under such coverage;

(2) for activities that improve health care quality; and

(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this section available to the public on the Internet website of the Department of Health and Human Services.

**(b) Ensuring that consumers receive value for their premium payments**

**(1) Requirement to provide value for premium payments**

**(A) Requirement**

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

(i) with respect to a health insurance issuer offering coverage in the large group market, 85 percent, or such higher percentage as a State may by regulation determine; or

(ii) with respect to a health insurance issuer offering coverage in the small group market or in the individual market, 80 percent, or such higher percentage as a State may by regulation determine, except that the Secretary may adjust such percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.

**(B) Rebate amount**

**(i) Calculation of amount**

The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of—

(I) the amount by which the percentage described in clause (i) or (ii) of subparagraph (A) exceeds the ratio described in such subparagraph; and

(II) the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for such plan year.

**(ii) Calculation based on average ratio**

Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

**(2) Consideration in setting percentages**

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

**(3) Enforcement**

The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

[2] So in original. Probably should be ''subsection (d),''.