(c) Definitions

Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) Adjustments

The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) Standard hospital charges

Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2718, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(f), Mar. 23, 2010, 124 Stat. 136, 885.)

AMENDMENTS

2010—Pub. L. 111–148, § 10101(f), amended section generally. Prior to amendment, the section related to clear accounting for costs, ensuring that consumers receive value for premiums, standard hospital charges, and definitions.

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–19. Appeals process

(a) Internal claims appeals

(1) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

(A) have in effect an internal claims appeal process;

(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 300gg–93 of this title to assist such enrollees with the appeals processes; and

(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

(2) Established processes

To comply with paragraph (1)—

(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on March 23, 2010), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

(b) External review

A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

(c) Secretary authority

The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

(July 1, 1944, ch. 373, title XXVII, § 2719, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(g), Mar. 23, 2010, 124 Stat. 137, 887.)

AMENDMENTS

2010—Pub. L. 111–148, § 10101(g), amended section generally. Prior to amendment, section related to implementation of appeals process by group health plans and health insurance issuers.

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–19a. Patient protections

(a) Choice of health care professional

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance issuer,[1] provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;[2]

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701[3] of this Act, section 1181 of title 29, or section 9801 of title 26, and other than applicable cost-sharing).

(2) Definitions

In this subsection:

(A) Emergency medical condition

The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1395dd(e)(1)(A) of this title.

(B) Emergency services

The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1395dd of this title) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1395dd of this title to stabilize the patient.

(C) Stabilize

The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give[4] in section 1395dd(e)(3) of this title.

(c) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(2) Construction

Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(d) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or

[1] So in original. Probably should be ''coverage,''.

[2] So in original. The word ''and'' probably should appear.

[3] See References in Text note below.

[4] So in original. Probably should be ''given''.