''(i) IN GENERAL.—If the plan administrator of any church group health plan which is maintained by the employer of a parent of a child or to which such an employer contributes receives an appropriately completed National Medical Support Notice promulgated pursuant to subsection (b) of this section [section 401(b) of Pub. L. 105–200, 42 U.S.C. 651 note] in the case of such child, and the Notice meets the requirements of paragraphs (3) and (4) of this subsection, the Notice shall be deemed to be a qualified medical child support order in the case of such child.

''(ii) ENROLLMENT OF CHILD IN PLAN.—In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a participant under a church group health plan who is a parent of the child, and the Notice is deemed under clause (i) to be a qualified medical child support order, the plan administrator, within 40 business days after the date of the Notice, shall—

''(I) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or any steps necessary to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to paragraph (3)(A)) to effectuate the coverage; and

''(II) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed as requiring a church group health plan, upon receipt of a National Medical Support Notice, to provide benefits under the plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the plan as of immediately before receipt of such Notice.

''(6) DIRECT PROVISION OF BENEFITS PROVIDED TO ALTERNATE RECIPIENTS.—Any payment for benefits made by a church group health plan pursuant to a medical child support order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

''(7) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a church group health plan to an official of a State or a political subdivision thereof whose name and address have been substituted for the address of an alternate recipient in a medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this subsection and part D of title IV of the Social Security Act [42 U.S.C. 651 et seq.], as payment of benefits to the alternate recipient.

''(8) EFFECTIVE DATE.—The provisions of this subsection shall take effect on the date of the issuance of interim regulations pursuant to subsection (b)(4) of this section [section 401(b)(4) of Pub. L. 105–200, 42 U.S.C. 651 note].

''(g) REPORT AND RECOMMENDATIONS REGARDING THE ENFORCEMENT OF QUALIFIED MEDICAL CHILD SUPPORT ORDERS.—Not later than 8 months after the issuance of the report to the Congress pursuant to subsection (a)(5) [section 401(a)(5) of Pub. L. 105–200, 42 U.S.C. 651 note], the Secretary of Health and Human Services and the Secretary of Labor shall jointly submit to each House of the Congress a report containing recommendations for appropriate legislation to improve the effectiveness of, and enforcement of, qualified medical child support orders under the provisions of subsection (f) of this section and section 609(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)).''

PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1994

For provisions setting forth circumstances under which any amendment to a plan required to be made by an amendment made by section 4301(d) of Pub. L. 103–66 shall not be required to be made before the first plan year beginning on or after Jan. 1, 1994, see section 4301(d) of Pub. L. 103–66, set out as an Effective Date of 1993 Amendment note under section 1021 of this title.

PART 7—GROUP HEALTH PLAN REQUIREMENTS

Subpart A—Requirements Relating to Portability, Access, and Renewability

§ 1181. Increased portability through limitation on preexisting condition exclusions

(a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage

Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term ''preexisting condition exclusion'' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term ''enrollment date'' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term ''late enrollee'' means, with respect to coverage under a group health plan, a

participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f).

(4) Waiting period

The term ''waiting period'' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this part, the term ''creditable coverage'' means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.; 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 1191b(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before January 1, 2014—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms ''TAA-eligible individual'' and ''TAA-related loss of coverage'' have the meanings given such terms in section 1165(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group health insurance coverage, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in

the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a

result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act, or child health assistance under a State child health plan under title XXI of such Act, in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents.

(II) Model notice

Not later than 1 year after February 4, 2009, the Secretary and the Secretary of Health and Human Services, in consultation with Directors of State Medicaid agencies under title XIX of the Social Security Act and Directors of State CHIP agencies under title XXI of such Act, shall jointly develop national and

State-specific model notices for purposes of subparagraph (A). The Secretary shall provide employers with such model notices so as to enable employers to timely comply with the requirements of subparagraph (A). Such model notices shall include information regarding how an employee may contact the State in which the employee resides for additional information regarding potential opportunities for such premium assistance, including how to apply for such assistance.

(III) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of this title.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of a participant or beneficiary of a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act [42 U.S.C. 1397ee(c)(2)(B), (3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if—

(A) no preexisting condition exclusion is imposed with respect to coverage through the organization,

(B) the period is applied uniformly without regard to any health status-related factors, and

(C) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) Defined

For purposes of this part, the term ''affiliation period'' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] for the State involved with respect to such issuer.

(Pub. L. 93–406, title I, § 701, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1939; amended Pub. L. 104–204, title VI, § 603(b)(3)(H), Sept. 26, 1996, 110 Stat. 2938; Pub. L. 111–3, title III, § 311(b)(1)(A), Feb. 4, 2009, 123 Stat. 65; Pub. L. 111–5, div. B, title I, § 1899D(b), Feb. 17, 2009, 123 Stat. 426; Pub. L. 111–344, title I, § 114(b), Dec. 29, 2010, 124 Stat. 3615; Pub. L. 112–40, title II, § 242(a)(2), Oct. 21, 2011, 125 Stat. 419.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsecs. (c)(1)(C), (D), (f)(3)(A)(i), (B)(i)(I), (II), (ii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Parts A and B of title XVIII of the Act are classified generally to parts A (§ 1395c et seq.) and B (§ 1395j et seq.) of subchapter XVIII of chapter 7 of Title 42, The Public Health and Welfare. Titles XIX and XXI of the Act are classified generally to subchapters XIX (§ 1396 et seq.) and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, referred to in subsec. (f)(3)(B)(ii), is section 311(b)(1)(C) of Pub. L. 111–3, which is set out as a note under this section.

The Public Health Service Act, referred to in subsec. (g)(3), is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of

title XXVII of the Act is classified generally to part A (§ 300gg et seq.) of subchapter XXV of chapter 6A of Title 42. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2011—Subsec. (c)(2)(C). Pub. L. 112–40 substituted ''January 1, 2014'' for ''February 13, 2011'' in introductory provisions.

2010—Subsec. (c)(2)(C). Pub. L. 111–344 substituted ''February 13, 2011'' for ''January 1, 2011'' in introductory provisions.

2009—Subsec. (c)(2)(C). Pub. L. 111–5 added subpar. (C).

Subsec. (f)(3). Pub. L. 111–3 added par. (3).

1996—Subsec. (c)(1). Pub. L. 104–204 made technical amendment to reference in original act which appears in text as reference to section 1191b of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2011 AMENDMENT

Amendment by Pub. L. 112–40 applicable to plan years beginning after Feb. 12, 2011, with transitional rules, see section 242(b) of Pub. L. 112–40, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by Pub. L. 111–344 applicable to plan years beginning after Dec. 31, 2010, see section 114(d) of Pub. L. 111–344, set out as a note under section 9801 of Title 26, Internal Revenue Code.

EFFECTIVE DATE OF 2009 AMENDMENT

Except as otherwise provided and subject to certain applicability provisions, amendment by Pub. L. 111–5 effective upon the expiration of the 90-day period beginning on Feb. 17, 2009, see section 1891 of Pub. L. 111–5, set out as an Effective and Termination Dates of 2009 Amendment note under section 2271 of Title 19, Customs Duties.

Amendment by Pub. L. 111–5 applicable to plan years beginning after Feb. 17, 2009, see section 1899D(d) of Pub. L. 111–5, set out as a note under section 9801 of Title 26, Internal Revenue Code.

Amendment by Pub. L. 111–3 effective Apr. 1, 2009, and applicable to child health assistance and medical assistance provided on or after that date, with certain exceptions, see section 3 of Pub. L. 111–3, set out as an Effective Date note under section 1396 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Pub. L. 104–191, title I, § 101(g), Aug. 21, 1996, 110 Stat. 1953, provided that:

''(1) IN GENERAL.—Except as provided in this section, this section [enacting this part and amending sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of this title] (and the amendments made by this section) shall apply with respect to group health plans for plan years beginning after June 30, 1997.

''(2) DETERMINATION OF CREDITABLE COVERAGE.—

''(A) PERIOD OF COVERAGE.—

''(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by this section) [this part] in determining creditable coverage.

''(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Labor, consistent with section 104 [42 U.S.C. 300gg–92 note], shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

''(B) CERTIFICATIONS, ETC.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 701 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(e)](as added by this section) shall apply to events occurring after June 30, 1996.

''(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

''(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

''(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

''(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

''(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section [enacting this part and amending sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of this title].

''(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act [Aug. 21, 1996], part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 [this part] (other than section 701(e) thereof [29 U.S.C. 1181(e)]) shall not apply to plan years beginning before the later of—

''(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

''(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

''(4) TIMELY REGULATIONS.—The Secretary of Labor, consistent with section 104 [42 U.S.C. 300gg–92 note], shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

''(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.''

WORKING GROUP TO DEVELOP MODEL COVERAGE COORDINATION DISCLOSURE FORM

Pub. L. 111–3, title III, § 311(b)(1)(C), Feb. 4, 2009, 123 Stat. 68, provided that:

''(i) MEDICAID, CHIP, AND EMPLOYER-SPONSORED COVERAGE COORDINATION WORKING GROUP.—

''(I) IN GENERAL.—Not later than 60 days after the date of enactment of this Act [Feb. 4, 2009], the Secretary of Health and Human Services and the Secretary of Labor shall jointly establish a Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group (in this subparagraph referred to as the 'Working Group'). The purpose of the Working Group shall be to develop the model coverage coordination disclosure form described in subclause (II) and to identify the impediments to the effective coordination of coverage available to families that include employees of employers that maintain group health plans and members who are eligible for medical assistance under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] or child health assistance or other health benefits coverage under title XXI of such Act [42 U.S.C. 1397aa et seq.].

''(II) MODEL COVERAGE COORDINATION DISCLOSURE FORM DESCRIBED.—The model form described in this subclause is a form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of the coverage available under such plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX or XXI of such Act and to allow for coordination of coverage for enrollees of such plans. Such form shall provide the following information in addition to such other information as the Working Group determines appropriate:

''(aa) A determination of whether the employee is eligible for coverage under the group health plan.

''(bb) The name and contract information of the plan administrator of the group health plan.

''(cc) The benefits offered under the plan.

''(dd) The premiums and cost-sharing required under the plan.

''(ee) Any other information relevant to coverage under the plan.

''(ii) MEMBERSHIP.—The Working Group shall consist of not more than 30 members and shall be composed of representatives of—

''(I) the Department of Labor;

''(II) the Department of Health and Human Services;

''(III) State directors of the Medicaid program under title XIX of the Social Security Act;

''(IV) State directors of the State Children's Health Insurance Program under title XXI of the Social Security Act;

''(V) employers, including owners of small businesses and their trade or industry representatives and certified human resource and payroll professionals;

''(VI) plan administrators and plan sponsors of group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]);

''(VII) health insurance issuers; and

''(VIII) children and other beneficiaries of medical assistance under title XIX of the Social Security Act or child health assistance or other health benefits coverage under title XXI of such Act.

''(iii) COMPENSATION.—The members of the Working Group shall serve without compensation.

''(iv) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services and the Department of Labor shall jointly provide appropriate administrative support to the Working Group, including technical assistance. The Working Group may use the services and facilities of either such Department, with or without reimbursement, as jointly determined by such Departments.

''(v) REPORT.—

''(I) REPORT BY WORKING GROUP TO THE SECRETARIES.—Not later than 18 months after the date of the enactment of this Act, the Working Group shall submit to the Secretary of Labor and the Secretary of Health and Human Services the model form described in clause (i)(II) along with a report containing recommendations for appropriate measures to address the impediments to the effective coordination of coverage between group health plans and the State plans under titles XIX and XXI of the Social Security Act.

''(II) REPORT BY SECRETARIES TO THE CONGRESS.—Not later than 2 months after receipt of the report pursuant to subclause (I), the Secretaries shall jointly submit a report to each House of the Congress regarding the recommendations contained in the report under such subclause.

''(vi) TERMINATION.—The Working Group shall terminate 30 days after the date of the issuance of its report under clause (v).''

[For definitions of ''CHIP'' and ''Medicaid'' as used in section 311(b)(1)(C) of Pub. L. 111–3, set out above, see section 1(c)(1), (2) of Pub. L. 111–3, set out as a Definitions note under section 1396 of Title 42, The Public Health and Welfare.]

IMPLEMENTATION OF 2009 AMENDMENT

Pub. L. 111–3, title III, § 311(b)(1)(D), Feb. 4, 2009, 123 Stat. 69, provided that: ''The Secretary of Labor and the Secretary of Health and Human Services shall develop the initial model notices under section 701(f)(3)(B)(i)(II) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1181(f)(3)(B)(i)(II)], and the Secretary of Labor shall provide such notices to employers, not later than the date that is 1 year after the date of enactment of this Act [Feb. 4, 2009], and each employer shall provide the initial annual notices to such employer's employees beginning with the first plan year that begins after the date on which such initial model notices are first issued. The model coverage coordination disclosure form developed under subparagraph (C) [set out above] shall apply with respect to requests made by States beginning with the first plan year that begins after the date on which such model coverage coordination disclosure form is first issued.''

§ 1182. Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 1181 of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide

particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

(c) Genetic testing

(1) Limitation on requesting or requiring genetic testing

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(2) Rule of construction

Paragraph (1) shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

(3) Rule of construction regarding payment

(A) In general

Nothing in paragraph (1) shall be construed to preclude a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment (as such term is defined for the purposes of applying the regulations promulgated by the Secretary of Health and Human Services under part C of title XI of the Social Security Act [42 U.S.C. 1320d et seq.] and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) consistent with subsection (a).

(B) Limitation

For purposes of subparagraph (A), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request only the minimum amount of information necessary to accomplish the intended purpose.

(4) Research exception

Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, may request, but not require, that a participant or beneficiary undergo a genetic test if each of the following conditions is met:

(A) The request is made, in writing, pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that—

(i) compliance with the request is voluntary; and

(ii) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(C) No genetic information collected or acquired under this paragraph shall be used for underwriting purposes.

(D) The plan or issuer notifies the Secretary in writing that the plan or issuer is conducting activities pursuant to the exception provided for under this paragraph, including a description of the activities conducted.

(E) The plan or issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

(d) Prohibition on collection of genetic information

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information for underwriting purposes (as defined in section 1191b of this title).

(2) Prohibition on collection of genetic information prior to enrollment

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

(3) Incidental collection

If a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of paragraph (2) if such request, requirement, or purchase is not in violation of paragraph (1).

(e) Application to all plans

The provisions of subsections (a)(1)(F), (b)(3), (c), and (d), and subsection (b)(1) and section 1181 of this title with respect to genetic information, shall apply to group health plans and health insurance issuers without regard to section 1191a(a) of this title.

(f) Genetic information of a fetus or embryo

Any reference in this part to genetic information concerning an individual or family member of an individual shall—

(1) with respect to such an individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by such pregnant woman; and

(2) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

(Pub. L. 93–406, title I, § 702, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1945; amended Pub. L. 110–233, title I, § 101(a)–(c), May 21, 2008, 122 Stat. 883, 885.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (c)(3)(A), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Part C of title XI of the Act is classified generally to part C (§ 1320d et seq.) of subchapter XI of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Section 264 of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (c)(3)(A), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of Title 42, The Public Health and Welfare.

AMENDMENTS

2008—Subsec. (b)(2)(A). Pub. L. 110–233, § 101(a)(1), inserted ''except as provided in paragraph (3)'' before semicolon.

Subsec. (b)(3). Pub. L. 110–233, § 101(a)(2), added par. (3).

Subsecs. (c) to (e). Pub. L. 110–233, § 101(b), added subsecs. (c) to (e).

Subsec. (f). Pub. L. 110–233, § 101(c), added subsec. (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 101(f)(2) of Pub. L. 110–233, set out as a note under section 1132 of this title.

§ 1183. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements

A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than—

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) because the plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

(Pub. L. 93–406, title I, § 703, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1946.)

Subpart B—Other Requirements

§ 1185. Standards relating to benefits for mothers and newborns

(a) Requirements for minimum hospital stay following birth

(1) In general

A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) Exception

Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

(b) Prohibitions

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Notice under group health plan

The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 1022(a)(1)[1] of this title, for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 1024(b)(1) of this title with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 1191(d)(1) of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 1191(a)(1) of this title shall not be construed as superseding a State law described in paragraph (1).

(Pub. L. 93–406, title I, §711, as added Pub. L. 104–204, title VI, §603(a)(5), Sept. 26, 1996, 110 Stat. 2935.)

[1] See References in Text note below.

Editorial Notes

REFERENCES IN TEXT

Section 1022(a)(1) of this title, referred to in subsec. (d), was redesignated section 1022(a) of this title by Pub. L. 105–34, title XV, §1503(b)(1)(B), Aug. 5, 1997, 111 Stat. 1061.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 1003 of this title.

§ 1185a. Parity in mental health and substance use disorder benefits

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

(B) Lifetime limit

If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable lifetime limit''), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits—

(A) No annual limit

If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

(B) Annual limit

If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ''applicable annual limit''), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder benefits that is less than the applicable annual limit.

(C) Rule in case of different limits

In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health and substance use disorder benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable

only with respect to mental health or substance use disorder benefits.

(B) Definitions

In this paragraph:

(i) Financial requirement

The term ''financial requirement'' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),[1]

(ii) Predominant

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation

The term ''treatment limitation'' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(6) Compliance program guidance document

(A) In general

The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 300gg–26 of title 42, and section 9812 of title 26, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled ''Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance''.

(B) Examples illustrating compliance and noncompliance

(i) In general

The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, based on investigations of violations of such sections, including—

(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

(II) descriptions of the violations uncovered during the course of such investigations.

(ii) Nonquantitative treatment limitations

To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

(iii) Access to additional information regarding compliance

In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable; and

(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(C) Recommendations

The compliance program guidance document shall include recommendations to ad-

[1] So in original. The comma probably should be a period.

vance compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

(D) Updating the compliance program guidance document

The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(7) Additional guidance

(A) In general

The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(B) Disclosure

(i) Guidance for plans and issuers

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).

(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

(C) Nonquantitative treatment limitations

The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable, (and any regulations promulgated pursuant to such respective section), including—

(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

(II) limitations with respect to prescription drug formulary design; and

(III) use of fail-first or step therapy protocols;

(ii) examples of methods of determining—

(I) network admission standards (such as credentialing); and

(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

(iii) examples of sources of information that may serve as evidentiary standards

for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(D) Public comment

Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

(8) Compliance requirements

(A) Nonquantitative treatment limitation (NQTL) requirements

In the case of a group health plan or a health insurance issuer offering group health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as ''NQTLs'') on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the Secretary, upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs, that applies to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

(B) Secretary request process

(i) Submission upon request

The Secretary shall request that a group health plan or a health insurance issuer offering group health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

(ii) Additional information

In instances in which the Secretary has concluded that the group health plan or health insurance issuer with respect to group health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a group health plan or health insurance issuer is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

(iii) Required action

(I) In general

In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or issuer is not in compliance; and

(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such coverage, has been determined to be not in compliance with this section.

(II) Exemption from disclosure

Documents or communications produced in connection with the Secretary's recommendations to a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5.

(iv) Report

Not later than 1 year after December 27, 2020, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

(I) a summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

(II) the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

(III) for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the disclosure requirements under this section;

(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

(V) the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.

(C) Compliance program guidance document update process

(i) In general

The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

(ii) Guidance and regulations

Not later than 18 months after December 27, 2020, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

(iii) State

The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) shall be shared with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).

(b) Construction

Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan

or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

(c) Exemptions

(1) Small employer exemption

(A) In general

This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

(B) Small employer

For purposes of subparagraph (A), the term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

(C) Application of certain rules in determination of employer size

For purposes of this paragraph—

(i) Application of aggregation rule for employers

Rules similar to the rules under subsections (b), (c), (m), and (*o*) of section 414 of title 26 shall apply for purposes of treating persons as a single employer.

(ii) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors

Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(2) Cost exemption

(A) In general

With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage

With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries

Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations

If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification

(i) In general

A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement

A notification to the Secretary under clause (i) shall include—

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage

with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality

A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies

To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(d) Separate application to each option offered

In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions

For purposes of this section—

(1) Aggregate lifetime limit

The term ''aggregate lifetime limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit

The term ''annual limit'' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits

The term ''medical or surgical benefits'' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

(4) Mental health benefits

The term ''mental health benefits'' means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits

The term ''substance use disorder benefits'' means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(f) Secretary report

The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

(g) Notice and assistance

The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.

(Pub. L. 93–406, title I, § 712, as added Pub. L. 104–204, title VII, § 702(a), Sept. 26, 1996, 110 Stat. 2944; amended Pub. L. 107–116, title VII, § 701(a), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–313, § 2(a), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108–197, § 2(a), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108–311, title III, § 302(b), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109–151, § 1(a), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, § 115(b), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, § 401(b), June 17, 2008, 122 Stat. 1649; Pub. L. 110–343, div. C, title V, § 512(a), (g)(1)(A), Oct. 3, 2008, 122 Stat. 3881, 3892; Pub. L. 116–260, div. BB, title II, § 203(a)(2), Dec. 27, 2020, 134 Stat. 2903.)

Editorial Notes

AMENDMENTS

2020—Subsec. (a)(6) to (8). Pub. L. 116–260 added pars. (6) to (8).

2008—Pub. L. 110–343, § 512(g)(1)(A), amended section catchline generally. Prior to amendment, catchline read as follows: ''Parity in application of certain limits to mental health benefits''.

Subsec. (a)(1), (2). Pub. L. 110–343, § 512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110–343, § 512(a)(7), substituted ''mental health and substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110–343, § 512(a)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110–343, §512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (b)(2). Pub. L. 110–343, §512(a)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).''

Subsec. (c)(1)(B). Pub. L. 110–343, §512(a)(3)(A), inserted ''(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)'' after ''of at least 2'' and struck out ''and who employs at least 2 employees on the first day of the plan year'' after ''preceding calendar year''.

Subsec. (c)(2). Pub. L. 110–343, §512(a)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: ''This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.''

Subsec. (e)(3). Pub. L. 110–343, §512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (e)(4). Pub. L. 110–343, §512(a)(8), which directed amendment of this section by substituting ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing (except in provisions amended by Pub. L. 110–343, §512(a)(7)), was not executed to par. (4) as added by Pub. L. 110–343, §512(a)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110–343, §512(a)(4), added par. (4) and struck out former par. (4). Text read as follows: ''The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.''

Subsec. (e)(5). Pub. L. 110–343, §512(a)(4), added par. (5).

Subsec. (f). Pub. L. 110–343, §512(a)(6), added subsec. (f).

Pub. L. 110–343, §512(a)(5), struck out subsec. (f). Text read as follows: ''This section shall not apply to benefits for services furnished—

''(1) on or after January 1, 2008, and before June 17, 2008, and

''(2) after December 31, 2008..''

Pub. L. 110–245 substituted ''services furnished—'' for ''services furnished after December 31, 2007'' and added pars. (1) and (2).

Subsec. (g). Pub. L. 110–343, §512(a)(6), added subsec. (g).

2006—Subsec. (f). Pub. L. 109–432 substituted ''2007'' for ''2006''.

2005—Subsec. (f). Pub. L. 109–151 substituted ''December 31, 2006'' for ''December 31, 2005''.

2004—Subsec. (f). Pub. L. 108–311 substituted ''after December 31, 2005'' for ''on or after December 31, 2004''.

2003—Subsec. (f). Pub. L. 108–197 substituted ''December 31, 2004'' for ''December 31, 2003''.

2002—Subsec. (f). Pub. L. 107–313 substituted ''December 31, 2003'' for ''December 31, 2002''.

Pub. L. 107–116 substituted ''December 31, 2002'' for ''September 30, 2001''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–343 applicable with respect to group health plans for plan years beginning after the date that is 1 year after Oct. 3, 2008, except that amendment by section 512(a)(5) of Pub. L. 110–343 effective Jan. 1, 2009, with special rule for collective bargaining agreements, see section 512(e) of Pub. L. 110–343, set out as a note under section 300gg–26 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE

Pub. L. 104–204, title VII, §702(c), Sept. 26, 1996, 110 Stat. 2946, provided that: ''The amendments made by this section [enacting this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

§ 1185b. Required coverage for reconstructive surgery following mastectomies

(a) In general

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) Notice

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

(2) as part of any yearly informational packet sent to the participant or beneficiary; or

(3) not later than January 1, 1999;

whichever is earlier.

(c) Prohibitions

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Rule of construction

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) Preemption, relation to State laws

(1) In general

Nothing in this section shall be construed to preempt any State law in effect on October 21, 1998, with respect to health insurance coverage that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) ERISA

Nothing in this section shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(Pub. L. 93–406, title I, § 713, as added Pub. L. 105–277, div. A, § 101(f) [title IX, § 902(a)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–436.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Pub. L. 105–277, div. A, § 101(f) [title IX, § 902(c)], Oct. 21, 1998, 112 Stat. 2681–337, 2681–438, provided that:

''(1) IN GENERAL.—The amendments made by this section [enacting this section] shall apply with respect to plan years beginning on or after the date of enactment of this Act [Oct. 21, 1998].

''(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.''

§ 1185c. Coverage of dependent students on medically necessary leave of absence

(a) Medically necessary leave of absence

In this section, the term ''medically necessary leave of absence'' means, with respect to a dependent child described in subsection (b)(2) in connection with a group health plan or health insurance coverage offered in connection with such plan, a leave of absence of such child from a postsecondary educational institution (including an institution of higher education as defined in section 1002 of title 20), or any other change in enrollment of such child at such an institution, that—

(1) commences while such child is suffering from a serious illness or injury;

(2) is medically necessary; and

(3) causes such child to lose student status for purposes of coverage under the terms of the plan or coverage.

(b) Requirement to continue coverage

(1) In general

In the case of a dependent child described in paragraph (2), a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, shall not terminate coverage of such child under such plan or health insurance coverage due to a medically necessary leave of absence before the date that is the earlier of—

(A) the date that is 1 year after the first day of the medically necessary leave of absence; or

(B) the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

(2) Dependent child described

A dependent child described in this paragraph is, with respect to a group health plan or health insurance coverage offered in connection with the plan, a beneficiary under the plan who—

(A) is a dependent child, under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage; and

(B) was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution (as described in subsection (a)), immediately before the first day of the medically necessary leave of absence involved.

(3) Certification by physician

Paragraph (1) shall apply to a group health plan or health insurance coverage offered by an issuer in connection with such plan only if the plan or issuer of the coverage has received written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) described in subsection (a) is medically necessary.

(c) Notice

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this section for continued coverage during medically necessary leaves of absence. Such description shall be in language which is understandable to the typical plan participant.

(d) No change in benefits

A dependent child whose benefits are continued under this section shall be entitled to the same benefits as if (during the medically necessary leave of absence) the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

(e) Continued application in case of changed coverage

If—

(1) a dependent child of a participant or beneficiary is in a period of coverage under a group health plan or health insurance cov-

erage offered in connection with such a plan, pursuant to a medically necessary leave of absence of the child described in subsection (b);

(2) the manner in which the participant or beneficiary is covered under the plan changes, whether through a change in health insurance coverage or health insurance issuer, a change between health insurance coverage and self-insured coverage, or otherwise; and

(3) the coverage as so changed continues to provide coverage of beneficiaries as dependent children,

this section shall apply to coverage of the child under the changed coverage for the remainder of the period of the medically necessary leave of absence of the dependent child under the plan in the same manner as it would have applied if the changed coverage had been the previous coverage.

(Pub. L. 93–406, title I, §714, as added Pub. L. 110–381, §2(a)(1), Oct. 9, 2008, 122 Stat. 4081.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110–381, set out as a note under section 9813 of Title 26, Internal Revenue Code.

§ 1185d. Additional market reforms

(a) General rule

Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and

(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) Exception

Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act [42 U.S.C. 300gg–16, 300gg–18] (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(Pub. L. 93–406, title I, §715, as added Pub. L. 111–148, title I, §1563(e), formerly §1562(e), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 270, 911.)

Editorial Notes

REFERENCES IN TEXT

The Public Health Service Act, referred to in text, is act July 1, 1944, ch. 373, 58 Stat. 682. Part A of title XXVII of the Act is classified generally to part A (§300gg et seq.) of subchapter XXV of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

The Patient Protection and Affordable Care Act, referred to in text, 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 Title 42, The Public Health and Welfare, and Tables.

CODIFICATION

Pub. L. 111–148, which directed amendment of subpart B of part 7 of ''subtitle A'' of title I of the Employee Retirement Income Security Act of 1974 by adding this section at the end, was executed by adding this section at the end of this subpart, which is subpart B of part 7 of subtitle B of title I of the Act, to reflect the probable intent of Congress.

§ 1185e. Preventing surprise medical bills

(a) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

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

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

(C) in a manner so that, if such services are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility—

(i) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively—

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an ini-

tial payment or notice of denial of payment; and

(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph (3)(K)) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

(v) any cost-sharing payments made by the participant or beneficiary with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

(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 300gg–3 of title 42, including as incorporated pursuant to section 1185d of this title and section 9815 of title 26, and other than applicable cost-sharing).

(2) Regulations for qualifying payment amounts

Not later than July 1, 2021, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall establish through rulemaking—

(A) the methodology the group health plan or health insurance issuer offering health insurance coverage in the group market shall use to determine the qualifying payment amount, differentiating by large group market, and small group market;

(B) the information such plan or issuer, respectively, shall share with the nonparticipating provider or nonparticipating facility, as applicable, when making such a determination;

(C) the geographic regions applied for purposes of this subparagraph, taking into account access to items and services in rural and underserved areas, including health professional shortage areas, as defined in section 254e of title 42; and

(D) a process to receive complaints of violations of the requirements described in subclauses (I) and (II) of subparagraph (A)(i) by group health plans and health insurance issuers offering health insurance coverage in the group market.

Such rulemaking shall take into account payments that are made by such plan or issuer, respectively, that are not on a fee-for-service basis. Such methodology may account for relevant payment adjustments that take into account quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account for purposes of determining payment amounts with respect to participating facilities. In carrying out clause (iii), the Secretary shall consult with the National Association of Insurance Commissioners to establish the geographic regions under such clause and shall periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act.

(3) Definitions

In this subpart:

(A) Emergency department of a hospital

The term ''emergency department of a hospital'' includes a hospital outpatient department that provides emergency services (as defined in subparagraph (C)(i)).

(B) 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 1867(e)(1)(A) of the Social Security Act [42 U.S.C. 1395dd(e)(1)(A)].

(C) Emergency services

(i) In general

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

(I) a medical screening examination (as required under section 1867 of the Social Security Act [42 U.S.C. 1395dd], or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, 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 or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required under section 1867 of such Act [42 U.S.C. 1395dd], or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

(ii) Inclusion of additional services

(I) In general

For purposes of this subsection and section 300gg–131 of title 42, in the case

of a participant or beneficiary who is enrolled in a group health plan or group health insurance coverage offered by a health insurance issuer and who is furnished services described in clause (i) with respect to an emergency medical condition, the term ''emergency services'' shall include, unless each of the conditions described in subclause (II) are met, in addition to the items and services described in clause (i), items and services—

(aa) for which benefits are provided or covered under the plan or coverage, respectively; and

(bb) that are furnished by a nonparticipating provider or nonparticipating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after the participant or beneficiary is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in clause (i) are furnished.

(II) Conditions

For purposes of subclause (I), the conditions described in this subclause, with respect to a participant or beneficiary who is stabilized and furnished additional items and services described in subclause (I) after such stabilization by a provider or facility described in subclause (I), are the following;

(aa) Such provider or facility determines such individual is able to travel using nonmedical transportation or nonemergency medical transportation.

(bb) Such provider furnishing such additional items and services satisfies the notice and consent criteria of section 300gg–132(d)[1] of title 42 with respect to such items and services.

(cc) Such individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the information described in section 300gg–132[1] of title 42 and to provide informed consent under such section, in accordance with applicable State law.

(dd) Such other conditions, as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

(D) Independent freestanding emergency department

The term ''independent freestanding emergency department'' means a health care facility that—

(i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and

(ii) provides any of the emergency services (as defined in subparagraph (C)(i)).

[1] See References in Text note below.

(E) Qualifying payment amount

(i) In general

The term ''qualifying payment amount'' means, subject to clauses (ii) and (iii), with respect to a sponsor of a group health plan and health insurance issuer offering group health insurance coverage—

(I) for an item or service furnished during 2022, the median of the contracted rates recognized by the plan or issuer, respectively (determined with respect to all such plans of such sponsor or all such coverage offered by such issuer that are offered within the same insurance market (specified in subclause (I), (II), or (III) of clause (iv)) as the plan or coverage) as the total maximum payment (including the cost-sharing amount imposed for such item or service and the amount to be paid by the plan or issuer, respectively) under such plans or coverage, respectively, on January 31, 2019, for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished, consistent with the methodology established by the Secretary under paragraph (2), increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over 2019, such percentage increase over 2020, and such percentage increase over 2021; and

(II) for an item or service furnished during 2023 or a subsequent year, the qualifying payment amount determined under this clause for such an item or service furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(ii) New plans and coverage

The term ''qualifying payment amount'' means, with respect to a sponsor of a group health plan or health insurance issuer offering group health insurance coverage in a geographic region in which such sponsor or issuer, respectively, did not offer any group health plan or health insurance coverage during 2019—

(I) for the first year in which such group health plan or health insurance coverage, respectively, is offered in such region, a rate (determined in accordance with a methodology established by the Secretary) for items and services that are covered by such plan and furnished during such first year; and

(II) for each subsequent year such group health plan or health insurance coverage, respectively, is offered in such region, the qualifying payment amount determined under this clause for such items and services furnished in the previous year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year.

(iii) Insufficient information; newly covered items and services

In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019 (or, in the case of a newly covered item or service (as defined in clause (v)(III)), in the first coverage year (as defined in clause (v)(I)) for such item or service with respect to such plan or coverage) for an item or service (including with respect to provider type, or amount, of claims for items or services (as determined by the Secretary) provided in a particular geographic region (other than in a case with respect to which clause (ii) applies)) the term ''qualifying payment amount''—

(I) for an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for such item or service with respect to such plan or coverage), means such rate for such item or service determined by the sponsor or issuer, respectively, through use of any database that is determined, in accordance with rulemaking described in paragraph (2), to not have any conflicts of interest and to have sufficient information reflecting allowed amounts paid to a health care provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database);

(II) for an item or service furnished in a subsequent year (before the first sufficient information year (as defined in clause (v)(II)) for such item or service with respect to such plan or coverage), means the rate determined under subclause (I) or this subclause, as applicable, for such item or service for the year previous to such subsequent year, increased by the percentage increase in the consumer price index for all urban consumers (United States city average) over such previous year;

(III) for an item or service furnished in the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given the term qualifying payment amount in clause (i)(I), except that in applying such clause to such item or service, the reference to ''furnished during 2022'' shall be treated as a reference to furnished during such first sufficient information year, the reference to ''in 2019'' [1] shall be treated as a reference to such sufficient information year, and the increase described in such clause shall not be applied; and

(IV) for an item or service furnished in any year subsequent to the first sufficient information year for such item or service with respect to such plan or coverage, has the meaning given such term in clause (i)(II), except that in applying such clause to such item or service, the reference to ''furnished during 2023 or a subsequent year'' shall be treated as a reference to furnished during the year after such first sufficient information year or a subsequent year.

(iv) Insurance market

For purposes of clause (i)(I), a health insurance market specified in this clause is one of the following:

(I) The large group market (other than plans described in subclause (III)).

(II) The small group market (other than plans described in subclause (III)).

(III) In the case of a self-insured group health plan, other self-insured group health plans.

(v) Definitions

For purposes of this subparagraph:

(I) First coverage year

The term ''first coverage year'' means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer and an item or service for which coverage is not offered in 2019 under such plan or coverage, the first year after 2019 for which coverage for such item or service is offered under such plan or health insurance coverage.

(II) First sufficient information year

The term ''first sufficient information year'' means, with respect to a group health plan or group health insurance coverage offered by a health insurance issuer—

(aa) in the case of an item or service for which the plan or coverage does not have sufficient information to calculate the median of the contracted rates described in clause (i)(I) in 2019, the first year subsequent to 2022 for which such sponsor or issuer has such sufficient information to calculate the median of such contracted rates in the year previous to such first subsequent year; and

(bb) in the case of a newly covered item or service, the first year subsequent to the first coverage year for such item or service with respect to such plan or coverage for which the sponsor or issuer has sufficient information to calculate the median of the contracted rates described in clause (i)(I) in the year previous to such first subsequent year.

(III) Newly covered item or service

The term ''newly covered item or service'' means, with respect to a group health plan or health insurance issuer offering group health insurance coverage, an item or service for which coverage was not offered in 2019 under such plan or coverage, but is offered under such plan or coverage in a year after 2019.

(F) Nonparticipating emergency facility; participating emergency facility

(i) Nonparticipating emergency facility

The term ''nonparticipating emergency facility'' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating emergency facility

The term ''participating emergency facility'' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to the furnishing of such an item or service at such facility.

(G) Nonparticipating providers; participating providers

(i) Nonparticipating provider

The term ''nonparticipating provider'' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(ii) Participating provider

The term ''participating provider'' means, with respect to an item or service and a group health plan or group health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing such item or service under the plan or coverage, respectively.

(H) Recognized amount

The term ''recognized amount'' means, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

(ii) subject to clause (iii), in the case of such item or service furnished in a State that does not have in effect a specified State law, with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount that is the qualifying payment amount (as defined in subparagraph (E))[2] for such year and determined in accordance with rulemaking described in paragraph (2))[2] for such item or service; or

(iii) in the case of such item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(I) Specified State law

The term ''specified State law'' means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of this title) in the case of a participant or beneficiary covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

(J) Stabilize

The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (B)), has the meaning give[3] in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(K) Out-of-network rate

The term ''out-of-network rate'' means, with respect to an item or service furnished in a State during a year to a participant or beneficiary of a group health plan or group health insurance coverage offered by a health insurance issuer receiving such item or service from a nonparticipating provider or nonparticipating emergency facility—

(i) subject to clause (iii), in the case of such item or service furnished in a State that has in effect a specified State law with respect to such plan, coverage, or issuer, respectively; such a nonparticipating provider or nonparticipating emergency facility; and such an item or service, the amount determined in accordance with such law;

[2] Closing parentheses so in original.

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

(ii) subject to clause (iii), in the case such State does not have in effect such a law with respect to such item or service, plan, and provider or facility—

(I) subject to subclause (II), if the provider or facility (as applicable) and such plan or coverage agree on an amount of payment (including if such agreed on amount is the initial payment sent by the plan under subsection (a)(1)(C)(iv)(I), subsection (b)(1)(C), or section 1185f(a)(3)(A) of this title, as applicable, or is agreed on through open negotiations under subsection (c)(1)) with respect to such item or service, such agreed on amount; or

(II) if such provider or facility (as applicable) and such plan or coverage enter the independent dispute resolution process under subsection (c) and do not so agree before the date on which a certified IDR entity (as defined in paragraph (4) of such subsection) makes a determination with respect to such item or service under such subsection, the amount of such determination; or

(iii) in the case such State has an All-Payer Model Agreement under section 1115A of the Social Security Act [42 U.S.C. 1315a], the amount that the State approves under such system for such item or service so furnished.

(L) Cost-sharing

The term ''cost-sharing'' includes copayments, coinsurance, and deductibles.

(b) Coverage of non-emergency services performed by nonparticipating providers at certain participating facilities

(1) In general

In the case of items or services (other than emergency services to which subsection (a) applies) for which any benefits are provided or covered by a group health plan or health insurance issuer offering group health insurance coverage furnished to a participant or beneficiary of such plan or coverage by a nonparticipating provider (as defined in subsection (a)(3)(G)(i)) (and who, with respect to such items and services, has not satisfied the notice and consent criteria of section 300gg–132(d) of title 42) with respect to a visit (as defined by the Secretary in accordance with paragraph (2)(B)) at a participating health care facility (as defined in paragraph (2)(A)), with respect to such plan or coverage, respectively, the plan or coverage, respectively—

(A) shall not impose on such participant or beneficiary a cost-sharing requirement for such items and services so furnished that is greater than the cost-sharing requirement that would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider (as defined in subsection (a)(3)(G)(ii));

(B) shall calculate such cost-sharing requirement as if the total amount that would have been charged for such items and services by such participating provider were equal to the recognized amount (as defined in subsection (a)(3)(H)) for such items and services, plan or coverage, and year;

(C) not later than 30 calendar days after the bill for such items or services is transmitted by such provider, shall send to the provider an initial payment or notice of denial of payment;

(D) shall pay a total plan or coverage payment directly, in accordance, if applicable, with the timing requirement described in subsection (c)(6), to such provider furnishing such items and services to such participant or beneficiary that is, with application of any initial payment under subparagraph (C), equal to the amount by which the out-of-network rate (as defined in subsection (a)(3)(K)) for such items and services exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such items and services (as determined in accordance with subparagraphs (A) and (B)) and year; and

(E) shall count toward any in-network deductible and in-network out-of-pocket maximums (as applicable) applied under the plan or coverage, respectively, any cost-sharing payments made by the participant or beneficiary (and such in-network deductible and out-of-pocket maximums shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider.

(2) Definitions

In this section:

(A) Participating health care facility

(i) In general

The term ''participating health care facility'' means, with respect to an item or service and a group health plan or health insurance issuer offering group health insurance coverage, a health care facility described in clause (ii) that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such an item or service at the facility.

(ii) Health care facility described

A health care facility described in this clause, with respect to a group health plan or group health insurance coverage, is each of the following:

(I) A hospital (as defined in 1861(e) of the Social Security Act [42 U.S.C. 1395x(e)]).

(II) A hospital outpatient department.

(III) A critical access hospital (as defined in section 1861(mm)(1) of such Act [42 U.S.C. 1395x(mm)(1)]).

(IV) An ambulatory surgical center described in section 1833(i)(1)(A) of such Act [42 U.S.C. 1395*l*(i)(1)(A)].

(V) Any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the plan or coverage, respectively.

(B) Visit

The term ''visit'' shall, with respect to items and services furnished to an individual at a health care facility, include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility.

(c) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to an item or service furnished in a year by a nonparticipating provider or a nonparticipating facility, with respect to a group health plan or health insurance issuer offering group health insurance coverage, in a State described in subsection (a)(3)(K)(ii) with respect to such plan or coverage and provider or facility, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(1) or (b)(1), the provider or facility (as applicable) or plan or coverage may, during the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment for such item or service, initiate open negotiations under this paragraph between such provider or facility and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider or facility, respectively, and such plan or coverage for payment (including any cost-sharing) for such item or service. For purposes of this subsection, the open negotiation period, with respect to an item or service, is the 30-day period beginning on the date of initiation of the negotiations with respect to such item or service.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to an item or service, that do not result in a determination of an amount of payment for such item or service by the last day of the open negotiation period described in such subparagraph with respect to such item or service, the provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the ''IDR process'') under which, in the case of an item or service with respect to which a provider or facility (as applicable) or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a ''qualified IDR item or service''), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such item or service furnished by such provider or facility.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for a qualified IDR item or service agree on a payment amount for such item or service during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of subsection (a)(3)(K)(ii) as the amount agreed to by such parties for such item or service. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg–132 of title 42 with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of items and services

(A) In general

Under the IDR process, the Secretary shall specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for pur-

poses of encouraging the efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if—

(i) such items and services to be included in such determination are furnished by the same provider or facility;

(ii) payment for such items and services is required to be made by the same group health plan or health insurance issuer;

(iii) such items and services are related to the treatment of a similar condition; and

(iv) such items and services were furnished during the 30 day[4] period following the date on which the first item or service included with respect to such determination was furnished or an alternative period as determined by the Secretary, for use in limited situations, such as by the consent of the parties or in the case of low-volume items and services, to encourage procedural efficiency and minimize health plan and provider administrative costs.

(B) Treatment of bundled payments

In carrying out subparagraph (A), the Secretary shall provide that, in the case of items and services which are included by a provider or facility as part of a bundled payment, such items and services included in such bundled payment may be part of a single determination under this subsection.

(4) Certification and selection of IDR entities

(A) In general

The Secretary, jointly with the Secretary of Health and Human Services and Secretary of the Treasury, shall establish a process to certify (including to recertify) entities under this paragraph. Such process shall ensure that an entity so certified—

(i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations described in paragraph (5) on a timely basis;

(ii) is not—

(I) a group health plan or health insurance issuer offering group health insurance coverage, provider, or facility;

(II) an affiliate or a subsidiary of such a group health plan or health insurance issuer, provider, or facility; or

(III) an affiliate or subsidiary of a professional or trade association of such group health plans or health insurance issuers or of providers or facilities;

(iii) carries out the responsibilities of such an entity in accordance with this subsection;

(iv) meets appropriate indicators of fiscal integrity;

(v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations;

(vi) does not under the IDR process carry out any determination with respect to which the entity would not pursuant to subclause (I), (II), or (III) of subparagraph (F)(i) be eligible for selection; and

(vii) meets such other requirements as determined appropriate by the Secretary.

(B) Period of certification

Subject to subparagraph (C), each certification (including a recertification) of an entity under the process described in subparagraph (A) shall be for a 5-year period.

(C) Revocation

A certification of an entity under this paragraph may be revoked under the process described in subparagraph (A) if the entity has a pattern or practice of noncompliance with any of the requirements described in such subparagraph.

(D) Petition for denial or withdrawal

The process described in subparagraph (A) shall ensure that an individual, provider, facility, or group health plan or health insurance issuer offering group health insurance coverage may petition for a denial of a certification or a revocation of a certification with respect to an entity under this paragraph for failure of meeting a requirement of this subsection.

(E) Sufficient number of entities

The process described in subparagraph (A) shall ensure that a sufficient number of entities are certified under this paragraph to ensure the timely and efficient provision of determinations described in paragraph (5).

(F) Selection of certified IDR entity

The Secretary shall, with respect to the determination of the amount of payment under this subsection of an item or service, provide for a method—

(i) that allows for the group health plan or health insurance issuer offering group health insurance coverage and the nonparticipating provider or the nonparticipating emergency facility (as applicable) involved in a notification under paragraph (1)(B) to jointly select, not later than the last day of the 3-business day period following the date of the initiation of the process with respect to such item or service, for purposes of making such determination, an entity certified under this paragraph that—

(I) is not a party to such determination or an employee or agent of such a party;

(II) does not have a material familial, financial, or professional relationship with such a party; and

(III) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(ii) that requires, in the case such parties do not make such selection by such last day, the Secretary to, not later than 6 business days after such date of initiation—

(I) select such an entity that satisfies subclauses (I) through (III) of clause (i)); and

[4] So in original. Probably should be ''30-day''.

(II) provide notification of such selection to the provider or facility (as applicable) and the plan or issuer (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the ''certified IDR entity'' with respect to such determination.

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the certified IDR entity shall—

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such item or service determined under this subsection for purposes of subsection (a)(1) or (b)(1), as applicable; and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for a qualified IDR item or service, the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination—

(i) shall each submit to the certified IDR entity with respect to such determination—

(I) an offer for a payment amount for such item or service furnished by such provider or facility; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR item or service shall consider—

(I) the qualifying payment amounts (as defined in subsection (a)(3)(E)) for the applicable year for items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR item or service; and

(II) subject to subparagraph (D), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to a qualified IDR item or service of a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer of group health insurance coverage the following:

(I) The level of training, experience, and quality and outcomes measurements of the provider or facility that furnished such item or service (such as those endorsed by the consensus-based entity authorized in section 1890 of the Social Security Act [42 U.S.C. 1395aaa]).

(II) The market share held by the nonparticipating provider or facility or that of the plan or issuer in the geographic region in which the item or service was provided.

(III) The acuity of the individual receiving such item or service or the complexity of furnishing such item or service to such individual.

(IV) The teaching status, case mix, and scope of services of the nonparticipating facility that furnished such item or service.

(V) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years.

(D) Prohibition on consideration of certain factors

In determining which offer is the payment to be applied with respect to qualified IDR items and services furnished by a provider or facility, the certified IDR entity with respect to a determination shall not consider usual and customary charges, the amount that would have been billed by such provider or facility with respect to such items and services had the provisions of section 300gg–131 of title 42 or section 300gg–132 of such title (as applicable) not applied, or the payment or reimbursement rate for such items and services furnished by such provider or facility payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(E) Effects of determination

(i) In general

A determination of a certified IDR entity under subparagraph (A)—

(I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and

(II) shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.

(ii) Suspension of certain subsequent IDR requests

In the case of a determination of a certified IDR entity under subparagraph (A), with respect to an initial notification submitted under paragraph (1)(B) with respect to qualified IDR items and services and the two parties involved with such notification, the party that submitted such notification may not submit during the 90-day period following such determination a subsequent notification under such paragraph involving the same other party to such notification with respect to such an item or service that was the subject of such initial notification.

(iii) Subsequent submission of requests permitted

In the case of a notification that pursuant to clause (ii) is not permitted to be submitted under paragraph (1)(B) during a 90-day period specified in such clause, if the end of the open negotiation period specified in paragraph (1)(A), that but for this clause would otherwise apply with respect to such notification, occurs during such 90-day period, such paragraph (1)(B) shall be applied as if the reference in such paragraph to the 4-day period beginning on the day after such open negotiation period were instead a reference to the 30-day period beginning on the day after the last day of such 90-day period.

(iv) Reports

The Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall examine the impact of the application of clause (ii) and whether the application of such clause delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations), and shall submit to Congress, not later than 2 years after the date of implementation of such clause an interim report (and not later than 4 years after such date of implementation, a final report) on whether any group health plans or health insurance issuers offering group or individual health insurance coverage or types of such plans or coverage have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day period described in such clause, including recommendations on ways to discourage such a pattern or practice.

(F) Costs of independent dispute resolution process

In the case of a notification under paragraph (1)(B) submitted by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group health insurance coverage and submitted to a certified IDR entity—

(i) if such entity makes a determination with respect to such notification under subparagraph (A), the party whose offer is not chosen under such subparagraph shall be responsible for paying all fees charged by such entity; and

(ii) if the parties reach a settlement with respect to such notification prior to such a determination, each party shall pay half of all fees charged by such entity, unless the parties otherwise agree.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(1) or (b)(1), with respect to a qualified IDR item or service for which a determination is made under paragraph (5)(A) or with respect to an item or service for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider or facility not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) Publication of information

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall make available on the public website of the Department of Labor—

(i) the number of notifications submitted under paragraph (1)(B) during such calendar quarter;

(ii) the size of the provider practices and the size of the facilities submitting notifications under paragraph (1)(B) during such calendar quarter;

(iii) the number of such notifications with respect to which a determination was made under paragraph (5)(A);

(iv) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made;

(v) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount, specified by items and services;

(vi) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vii) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(viii) the total amount of compensation paid to certified IDR entities under paragraph (5)(F) during such calendar quarter.

(B) Information

For purposes of subparagraph (A), the information described in this subparagraph is,

with respect to a notification under paragraph (1)(B) by a nonparticipating provider, nonparticipating emergency facility, group health plan, or health insurance issuer offering group health insurance coverage—

(i) a description of each item and service included with respect to such notification;

(ii) the geography in which the items and services with respect to such notification were provided;

(iii) the amount of the offer submitted under paragraph (5)(B) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider or nonparticipating emergency facility (as applicable) expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer submitted by such plan or issuer (as applicable) or by such provider or facility (as applicable) and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) the category and practice specialty of each such provider or facility involved in furnishing such items and services;

(vi) the identity of the health plan or health insurance issuer, provider, or facility, with respect to the notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary to carry out the provisions of this subsection.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (3)[5] in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period described in paragraph (5)(E)(ii), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(d) Certain access fees to certain databases

In the case of a sponsor of a group health plan or health insurance issuer offering group health insurance coverage that, pursuant to subsection (a)(3)(E)(iii), uses a database described in such subsection to determine a rate to apply under such subsection for an item or service by reason of having insufficient information described in such subsection with respect to such item or service, such sponsor or issuer shall cover the cost for access to such database.

(e) Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following:

(1) Any deductible applicable to such plan or coverage.

(2) Any out-of-pocket maximum limitation applicable to such plan or coverage.

(3) A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage[6]

(f) Advanced explanation of benefits

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan, or a health insurance issuer offering group health insurance coverage shall, with respect to a notification submitted under section 300gg–136 of title 42 by a health care provider or health care facility to the plan or issuer for a participant or beneficiary under plan or coverage scheduled to receive an item or service from the provider or facility (or authorized representative of

[5] So in original. Probably should be ''paragraph (4)''.

[6] So in original. Probably should be followed by a period.

such participant or beneficiary), not later than 1 business day (or, in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished (or in the case of a request made to such plan or coverage by such participant or beneficiary), 3 business days) after the date on which the plan or coverage receives such notification (or such request), 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) 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 and—

(i) in the case the provider or facility is a participating provider or facility with respect to the plan or coverage with respect to the furnishing of such item or service, the contracted rate under such plan for such item or service (based on the billing and diagnostic codes provided by such provider or facility); and

(ii) in the case the provider or facility is a nonparticipating provider or facility with respect to such plan or coverage, a description of how such individual may obtain information on providers and facilities that, with respect to such plan or coverage, are participating providers and facilities, if any.

(B) The good faith estimate included in the notification received from the provider or facility (if applicable) based on such codes.

(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).

(D) A good faith estimate of the amount of any cost-sharing for which the participant or beneficiary would be responsible for such item or service (as of the date of such notification).

(E) A good faith estimate of 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).

(F) In the case such item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage under the plan or coverage, a disclaimer that coverage for such item or service is subject to such medical management technique.

(G) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change.

(H) Any other information or disclaimer the plan or coverage determines appropriate that is consistent with information and disclaimers required under this section.

(2) Authority to modify timing requirements in the case of specified items and services

(A) In general

In the case of a participant or beneficiary scheduled to receive an item or service that is a specified item or service (as defined in subparagraph (B)), the Secretary may modify any timing requirements relating to the provision of the notification described in paragraph (1) to such participant or beneficiary with respect to such item or service. Any modification made by the Secretary pursuant to the previous sentence may not result in the provision of such notification after such participant or beneficiary has been furnished such item or service.

(B) Specified item or service defined

For purposes of subparagraph (A), the term ''specified item or service'' means an item or service that has low utilization or significant variation in costs (such as when furnished as part of a complex treatment), as specified by the Secretary.

(Pub. L. 93–406, title I, § 716, as added and amended Pub. L. 116–260, div. BB, title I, §§ 102(b)(1), 103(b), 107(b), 111(c), Dec. 27, 2020, 134 Stat. 2772, 2806, 2858, 2865.)

Editorial Notes

REFERENCES IN TEXT

Section 109(a) of the No Surprises Act, referred to in subsec. (a)(2), is section 109(a) of Pub. L. 116–260, div. BB, title I, Dec. 27, 2020, 134 Stat. 2859, which is not classified to the Code.

Section 300gg–132 of title 42, referred to in subsec. (a)(3)(C)(ii)(II)(bb), (cc), was in the original ''section 2799B–2'', which was translated as reading section 2799B–2 of the Public Health Service Act, to reflect the probable intent of Congress.

The phrase ''in 2019'', referred to in subsec. (a)(3)(E)(iii)(III), does not appear in cl. (i)(I) of subsec. (a)(3)(E). However, subsec. (a)(3)(E)(iii)(III) of section 9816 of Title 26, Internal Revenue Code, which contains text similar to that in this subclause, refers to the phrase ''on January 31, 2019'', which does appear in cl. (i)(I).

The Social Security Act, referred to in subsec. (c)(5)(D), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

AMENDMENTS

2020—Subsecs. (c), (d). Pub. L. 116–260, § 103(b), added subsec. (c) and redesignated former subsec. (c) as (d).

Subsec. (e). Pub. L. 116–260, § 107(b), added subsec. (e).

Subsec. (f). Pub. L. 116–260, § 111(c), added subsec. (f).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by section 107(b) of Pub. L. 116–260 applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 107(d) of div. BB of Pub. L. 116–260, set out as a note under section 9816 of Title 26, Internal Revenue Code.

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB

of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

§ 1185f. Ending surprise air ambulance bills

(a) In general

In the case of a participant or beneficiary who is in a group health plan or group health insurance coverage offered by a health insurance issuer and who receives air ambulance services from a nonparticipating provider (as defined in section 1185e(a)(3)(G) of this title) with respect to such plan or coverage, if such services would be covered if provided by a participating provider (as defined in such section) with respect to such plan or coverage—

(1) the cost-sharing requirement with respect to such services shall be the same requirement that would apply if such services were provided by such a participating provider, and any coinsurance or deductible shall be based on rates that would apply for such services if they were furnished by such a participating provider;

(2) such cost-sharing amounts shall be counted towards the in-network deductible and in-network out-of-pocket maximum amount under the plan or coverage for the plan year (and such in-network deductible shall be applied) with respect to such items and services so furnished in the same manner as if such cost-sharing payments were with respect to items and services furnished by a participating provider; and

(3) the group health plan or health insurance issuer, respectively, shall—

(A) not later than 30 calendar days after the bill for such services is transmitted by such provider, send to the provider, an initial payment or notice of denial of payment; and

(B) pay a total plan or coverage payment, in accordance with, if applicable, subsection (b)(6), directly to such provider furnishing such services to such participant, beneficiary, or enrollee that is, with application of any initial payment under subparagraph (A), equal to the amount by which the out-of-network rate (as defined in section 1185e(a)(3)(K) of this title) for such services and year involved exceeds the cost-sharing amount imposed under the plan or coverage, respectively, for such services (as determined in accordance with paragraphs (1) and (2)).

(b) Determination of out-of-network rates to be paid by health plans; independent dispute resolution process

(1) Determination through open negotiation

(A) In general

With respect to air ambulance services furnished in a year by a nonparticipating provider, with respect to a group health plan or health insurance issuer offering group health insurance coverage, and for which a payment is required to be made by the plan or coverage pursuant to subsection (a)(3), the provider or plan or coverage may, during the 30-day period beginning on the day the provider receives a payment or a statement of denial of payment from the plan or coverage regarding a claim for payment for such service, initiate open negotiations under this paragraph between such provider and plan or coverage for purposes of determining, during the open negotiation period, an amount agreed on by such provider, and such plan or coverage for payment (including any cost-sharing) for such service. For purposes of this subsection, the open negotiation period, with respect to air ambulance services, is the 30-day period beginning on the date of initiation of the negotiations with respect to such services.

(B) Accessing independent dispute resolution process in case of failed negotiations

In the case of open negotiations pursuant to subparagraph (A), with respect to air ambulance services, that do not result in a determination of an amount of payment for such services by the last day of the open negotiation period described in such subparagraph with respect to such services, the provider or group health plan or health insurance issuer offering group health insurance coverage that was party to such negotiations may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process under paragraph (2) with respect to such item or service. The independent dispute resolution process shall be initiated by a party pursuant to the previous sentence by submission to the other party and to the Secretary of a notification (containing such information as specified by the Secretary) and for purposes of this subsection, the date of initiation of such process shall be the date of such submission or such other date specified by the Secretary pursuant to regulations that is not later than the date of receipt of such notification by both the other party and the Secretary.

(2) Independent dispute resolution process available in case of failed open negotiations

(A) Establishment

Not later than 1 year after December 27, 2020, the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury, shall establish by regulation one independent dispute resolution process (referred to in this subsection as the ''IDR process'') under which, in the case of air ambulance services with respect to which a provider or group health plan or health insurance issuer offering group health insurance coverage submits a notification under paragraph (1)(B) (in this subsection referred to as a ''qualified IDR air ambulance services''), a certified IDR entity under paragraph (4) determines, subject to subparagraph (B) and in accordance with the succeeding provisions of this subsection, the amount of payment under the plan or coverage for such services furnished by such provider.

(B) Authority to continue negotiations

Under the independent dispute resolution process, in the case that the parties to a determination for qualified IDR air ambulance services agree on a payment amount for such services during such process but before the date on which the entity selected with respect to such determination under paragraph (4) makes such determination under paragraph (5), such amount shall be treated for purposes of section 1185e(a)(3)(K)(ii) of this title as the amount agreed to by such parties for such services. In the case of an agreement described in the previous sentence, the independent dispute resolution process shall provide for a method to determine how to allocate between the parties to such determination the payment of the compensation of the entity selected with respect to such determination.

(C) Clarification

A nonparticipating provider may not, with respect to an item or service furnished by such provider, submit a notification under paragraph (1)(B) if such provider is exempt from the requirement under subsection (a) of section 300gg–132 of title 42 with respect to such item or service pursuant to subsection (b) of such section.

(3) Treatment of batching of services

The provisions of section 1185e(c)(3) of this title shall apply with respect to a notification submitted under this subsection with respect to air ambulance services in the same manner and to the same extent such provisions apply with respect to a notification submitted under section 1185e(c) of this title with respect to items and services described in such section.

(4) IDR entities

(A) Eligibility

An IDR entity certified under this subsection is an IDR entity certified under section 1185e(c)(4) of this title.

(B) Selection of certified IDR entity

The provisions of subparagraph (F) of section 1185e(c)(4) of this title shall apply with respect to selecting an IDR entity certified pursuant to subparagraph (A) with respect to the determination of the amount of payment under this subsection of air ambulance services in the same manner as such provisions apply with respect to selecting an IDR entity certified under such section with respect to the determination of the amount of payment under section 1185e(c) of this title of an item or service. An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the ''certified IDR entity'' with respect to such determination.

(5) Payment determination

(A) In general

Not later than 30 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR ambulance services, the certified IDR entity shall—

(i) taking into account the considerations specified in subparagraph (C), select one of the offers submitted under subparagraph (B) to be the amount of payment for such services determined under this subsection for purposes of subsection (a)(3); and

(ii) notify the provider or facility and the group health plan or health insurance issuer offering group health insurance coverage party to such determination of the offer selected under clause (i).

(B) Submission of offers

Not later than 10 days after the date of selection of the certified IDR entity with respect to a determination for qualified IDR air ambulance services, the provider and the group health plan or health insurance issuer offering group health insurance coverage party to such determination—

(i) shall each submit to the certified IDR entity with respect to such determination—

(I) an offer for a payment amount for such services furnished by such provider; and

(II) such information as requested by the certified IDR entity relating to such offer; and

(ii) may each submit to the certified IDR entity with respect to such determination any information relating to such offer submitted by either party, including information relating to any circumstance described in subparagraph (C)(ii).

(C) Considerations in determination

(i) In general

In determining which offer is the payment to be applied pursuant to this paragraph, the certified IDR entity, with respect to the determination for a qualified IDR air ambulance service shall consider—

(I) the qualifying payment amounts (as defined in section 1185e(a)(3)(E) of this title) for the applicable year for items and services that are comparable to the qualified IDR air ambulance service and that are furnished in the same geographic region (as defined by the Secretary for purposes of such subsection) as such qualified IDR air ambulance service; and

(II) subject to clause (iii), information on any circumstance described in clause (ii), such information as requested in subparagraph (B)(i)(II), and any additional information provided in subparagraph (B)(ii).

(ii) Additional circumstances

For purposes of clause (i)(II), the circumstances described in this clause are, with respect to air ambulance services included in the notification submitted under paragraph (1)(B) of a nonparticipating provider, group health plan, or health insurance issuer the following:

(I) The quality and outcomes measurements of the provider that furnished such services.

(II) The acuity of the individual receiving such services or the complexity of furnishing such services to such individual.

(III) The training, experience, and quality of the medical personnel that furnished such services.

(IV) Ambulance vehicle type, including the clinical capability level of such vehicle.

(V) Population density of the pick up location (such as urban, suburban, rural, or frontier).

(VI) Demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the plan or issuer to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous 4 plan years.

(iii) Prohibition on consideration of certain factors

In determining which offer is the payment amount to be applied with respect to qualified IDR air ambulance services furnished by a provider, the certified IDR entity with respect to such determination shall not consider usual and customary charges, the amount that would have been billed by such provider with respect to such services had the provisions of section 300gg–135 of title 42 not applied, or the payment or reimbursement rate for such services furnished by such provider payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.], under the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.], under the Children's Health Insurance Program under title XXI of such Act [42 U.S.C. 1397aa et seq.], under the TRICARE program under chapter 55 of title 10, or under chapter 17 of title 38.

(D) Effects of determination

The provisions of section 1185e(c)(5)(E) of this title shall apply with respect to a determination of a certified IDR entity under subparagraph (A), the notification submitted with respect to such determination, the services with respect to such notification, and the parties to such notification in the same manner as such provisions apply with respect to a determination of a certified IDR entity under section 1185e(c)(5)(E) of this title, the notification submitted with respect to such determination, the items and services with respect to such notification, and the parties to such notification.

(E) Costs of independent dispute resolution process

The provisions of section 1185e(c)(5)(F) of this title shall apply to a notification made under this subsection, the parties to such notification, and a determination under subparagraph (A) in the same manner and to the same extent such provisions apply to a notification under section 1185e(c) of this title, the parties to such notification and a determination made under section 1185e(c)(5)(A) of this title.

(6) Timing of payment

The total plan or coverage payment required pursuant to subsection (a)(3), with respect to qualified IDR air ambulance services for which a determination is made under paragraph (5)(A) or with respect to air ambulance services for which a payment amount is determined under open negotiations under paragraph (1), shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made.

(7) Publication of information relating to the IDR process

(A) In general

For each calendar quarter in 2022 and each calendar quarter in a subsequent year, the Secretary shall publish on the public website of the Department of Labor—

(i) the number of notifications submitted under the IDR process during such calendar quarter;

(ii) the number of such notifications with respect to which a final determination was made under paragraph (5)(A);

(iii) the information described in subparagraph (B) with respect to each notification with respect to which such a determination was so made.[1]

(iv) the number of times the payment amount determined (or agreed to) under this subsection exceeds the qualifying payment amount;

(v) the amount of expenditures made by the Secretary during such calendar quarter to carry out the IDR process;

(vi) the total amount of fees paid under paragraph (8) during such calendar quarter; and

(vii) the total amount of compensation paid to certified IDR entities under paragraph (5)(E) during such calendar quarter.

(B) Information with respect to requests

For purposes of subparagraph (A), the information described in this subparagraph is, with respect to a notification under the IDR process of a nonparticipating provider, group health plan, or health insurance issuer offering group health insurance coverage—

(i) a description of each air ambulance service included in such notification;

(ii) the geography in which the services included in such notification were provided;

(iii) the amount of the offer submitted under paragraph (2) by the group health plan or health insurance issuer (as applicable) and by the nonparticipating provider expressed as a percentage of the qualifying payment amount;

(iv) whether the offer selected by the certified IDR entity under paragraph (5) to be the payment applied was the offer sub-

[1] So in original. The period probably should be a semicolon.

mitted by such plan or issuer (as applicable) or by such provider and the amount of such offer so selected expressed as a percentage of the qualifying payment amount;

(v) ambulance vehicle type, including the clinical capability level of such vehicle;

(vi) the identity of the group health plan or health insurance issuer or air ambulance provider with respect to such notification;

(vii) the length of time in making each determination;

(viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and

(ix) any other information specified by the Secretary.

(C) IDR entity requirements

For 2022 and each subsequent year, an IDR entity, as a condition of certification as an IDR entity, shall submit to the Secretary such information as the Secretary determines necessary for the Secretary to carry out the provisions of this paragraph.

(D) Clarification

The Secretary shall ensure the public reporting under this paragraph does not contain information that would disclose privileged or confidential information of a group health plan or health insurance issuer offering group or individual health insurance coverage or of a provider or facility.

(8) Administrative fee

(A) In general

Each party to a determination under paragraph (5) to which an entity is selected under paragraph (4) in a year shall pay to the Secretary, at such time and in such manner as specified by the Secretary, a fee for participating in the IDR process with respect to such determination in an amount described in subparagraph (B) for such year.

(B) Amount of fee

The amount described in this subparagraph for a year is an amount established by the Secretary in a manner such that the total amount of fees paid under this paragraph for such year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for such year in carrying out the IDR process.

(9) Waiver authority

The Secretary may modify any deadline or other timing requirement specified under this subsection (other than the establishment date for the IDR process under paragraph (2)(A) and other than under paragraph (6)) in cases of extenuating circumstances, as specified by the Secretary, or to ensure that all claims that occur during a 90-day period applied through paragraph (5)(D), but with respect to which a notification is not permitted by reason of such paragraph to be submitted under paragraph (1)(B) during such period, are eligible for the IDR process.

(c) Definition

For purposes of this section:

(1) Air ambulance services

The term ''air ambulance service'' means medical transport by helicopter or airplane for patients.

(2) Qualifying payment amount

The term ''qualifying payment amount'' has the meaning given such term in section 1185e(a)(3) of this title.

(3) Nonparticipating provider

The term ''nonparticipating provider'' has the meaning given such term in section 1185e(a)(3) of this title.

(Pub. L. 93–406, title I, § 717, as added Pub. L. 116–260, div. BB, title I, § 105(a)(2)(A), Dec. 27, 2020, 134 Stat. 2838.)

Editorial Notes

REFERENCES IN TEXT

The Social Security Act, referred to in subsec. (b)(5)(C)(iii), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles XVIII, XIX, and XXI of the Act are classified generally to subchapters XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see section 1305 of Title 42 and Tables.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 105(a)(4) of div. BB of Pub. L. 116–260, set out as a note under section 9817 of Title 26, Internal Revenue Code.

§ 1185g. Continuity of care

(a) Ensuring continuity of care with respect to terminations of certain contractual relationships resulting in changes in provider network status

(1) In general

In the case of an individual with benefits under a group health plan or group health insurance coverage offered by a health insurance issuer and with respect to a health care provider or facility that has a contractual relationship with such plan or such issuer (as applicable) for furnishing items and services under such plan or such coverage, if, while such individual is a continuing care patient (as defined in subsection (b)) with respect to such provider or facility—

(A) such contractual relationship is terminated (as defined in paragraph (b));

(B) benefits provided under such plan or such health insurance coverage with respect to such provider or facility are terminated because of a change in the terms of the participation of the provider or facility in such plan or coverage; or

(C) a contract between such group health plan and a health insurance issuer offering health insurance coverage in connection with such plan is terminated, resulting in a loss of benefits provided under such plan with respect to such provider or facility;

the plan or issuer, respectively, shall meet the requirements of paragraph (2) with respect to such individual.

(2) Requirements

The requirements of this paragraph are that the plan or issuer—

(A) notify each individual enrolled under such plan or coverage who is a continuing care patient with respect to a provider or facility at the time of a termination described in paragraph (1) affecting such provider or facility on a timely basis of such termination and such individual's right to elect continued transitional care from such provider or facility under this section;

(B) provide such individual with an opportunity to notify the plan or issuer of the individual's need for transitional care; and

(C) permit the patient to elect to continue to have benefits provided under such plan or such coverage, under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by such provider or facility relating to such individual's status as a continuing care patient during the period beginning on the date on which the notice under subparagraph (A) is provided and ending on the earlier of—

(i) the 90-day period beginning on such date; or

(ii) the date on which such individual is no longer a continuing care patient with respect to such provider or facility.

(b) Definitions

In this section:

(1) Continuing care patient

The term ''continuing care patient'' means an individual who, with respect to a provider or facility—

(A) is undergoing a course of treatment for a serious and complex condition from the provider or facility;

(B) is undergoing a course of institutional or inpatient care from the provider or facility;

(C) is scheduled to undergo nonelective surgery from the provide or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(E) is or was determined to be terminally ill (as determined under section 1395x(dd)(3)(A) of title 42) and is receiving treatment for such illness from such provider or facility.

(2) Serious and complex condition

The term ''serious and complex condition'' means, with respect to a participant or beneficiary under a group health plan or group health insurance coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(3) Terminated

The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

(Pub. L. 93–406, title I, §718, as added Pub. L. 116–260, div. BB, title I, §113(c)(1), Dec. 27, 2020, 134 Stat. 2871.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 113(e) of div. BB of Pub. L. 116–260, set out as a note under section 9818 of Title 26, Internal Revenue Code.

§ 1185h. Maintenance of price comparison tool

A group health plan or a health insurance issuer offering group health insurance coverage shall offer price comparison guidance by telephone and make available on the Internet website of the plan or issuer a price comparison tool that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.

(Pub. L. 93–406, title I, §719, as added Pub. L. 116–260, div. BB, title I, §114(c)(1), Dec. 27, 2020, 134 Stat. 2874.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 114(d) of div. BB of Pub. L. 116–260, set out as a note under section 9819 of Title 26, Internal Revenue Code.

§ 1185i. Protecting patients and improving the accuracy of provider directory information

(a) Provider directory information requirements

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall—

(A) establish the verification process described in paragraph (2);

(B) establish the response protocol described in paragraph (3);

(C) establish the database described in paragraph (4); and

(D) include in any directory (other than the database described in subparagraph (C))

containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

(2) Verification process

The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, a process—

(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 300gg–139 of title 42.

(3) Response protocol

The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call—

(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

(B) retains such communication in such individual's file for at least 2 years following such response.

(4) Database

The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group health insurance coverage, a database on the public website of such plan or issuer that contains—

(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

(B) provider directory information with respect to each such provider and facility.

(5) Information

The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

(6) Definition

For purposes of this subsection, the term ''provider directory information'' includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

(7) Rule of construction

Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories, to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of this title.

(b) Cost-sharing for services provided based on reliance on incorrect provider network information

(1) In general

For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant or beneficiary of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant or beneficiary and item or service, the plan or coverage—

(A) shall not impose on such participant or beneficiary a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

(2) Criteria described

For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant or beneficiary of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

(A) The participant or beneficiary received through a database, provider directory, or response protocol described in subsection (a)

information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

(B) The information was not provided, in accordance with subsection (a), to the participant or beneficiary and the participant or beneficiary requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

(c) Disclosure on patient protections against balance billing

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 1185e of this title applies—

(1) information in plain language on—

(A) the requirements and prohibitions applied under sections 300gg–131 and 300gg–132 of title 42 (relating to prohibitions on balance billing in certain circumstances);

(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant or beneficiary of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant or beneficiary; and

(C) the requirements applied under section 1185e of this title; and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

(Pub. L. 93–406, title I, §720, as added Pub. L. 116–260, div. BB, title I, §116(b), Dec. 27, 2020, 134 Stat. 2881.)

§ 1185k. Other patient protections

(a) Choice of health care professional

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

(b) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant or beneficiary under a group health plan, or group health insurance coverage offered by a health insurance issuer, 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.

(c) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group 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 or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) Obstetrical and gynecological care

A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) Application of paragraph

A group health plan, or health insurance issuer offering group health insurance coverage, described in this paragraph is a group health plan or coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant or beneficiary of a participating primary care provider.

(3) Construction

Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or

health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(Pub. L. 93–406, title I, § 722, as added Pub. L. 116–260, div. BB, title I, § 102(b)(2), Dec. 27, 2020, 134 Stat. 2783.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of div. BB of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

§ 1185*l*. Air ambulance report requirements

(a) In general

Each group health plan and health insurance issuer offering group health insurance coverage shall submit to the Secretary, jointly with the Secretary of Health and Human Services and the Secretary of the Treasury—

(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

(2) not later than the date that is 90 days after the last day of the plan year immediately succeeding the calendar year described in paragraph (1), such information with respect to such immediately succeeding plan year.

(b) Information described

For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, is each of the following:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

(C) Whether the transport in which the services were furnished originated in a rural or urban area.

(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

(2) Such other information regarding providers of air ambulance services as the Secretary may specify.

(Pub. L. 93–406, title I, § 723, as added Pub. L. 116–260, div. BB, title I, § 106(b)(2)(A), Dec. 27, 2020, 134 Stat. 2853.)

Editorial Notes

REFERENCES IN TEXT

Section 106(d) of the No Surprises Act, referred to in subsec. (a)(1), is section 106(d) of div. BB of Pub. L. 116–260, which is set out as a note under section 300gg–118 of Title 42, The Public Health and Welfare.

§ 1185m. Increasing transparency by removing gag clauses on price and quality information

(a) [1] Increasing price and quality transparency for plan sponsors and consumers

(1) In general

A group health plan (or an issuer of health insurance coverage offered in connection with such a plan) may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.], including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amend-

[1] So in original. There is no subsec. (b).

ments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.].

(2) Clarification regarding public disclosure of information

Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

(3) Attestation

A group health plan (or health insurance coverage offered in connection with such a plan) shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

(4) Rules of construction

Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.].

(Pub. L. 93–406, title I, §724, as added Pub. L. 116–260, div. BB, title II, §201(b), Dec. 27, 2020, 134 Stat. 2892.)

Editorial Notes

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(1)(B), (C), (4), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of Title 42, The Public Health and Welfare.

The Genetic Information Nondiscrimination Act of 2008, referred to in subsec. (a)(1)(B), (C), (4), is Pub. L. 110–233, May 21, 2008, 122 Stat. 881. For complete classification of this Act to the Code, see Short Title note set out under section 2000ff of Title 42, The Public Health and Welfare, and Tables.

The Americans with Disabilities Act of 1990, referred to in subsec. (a)(1)(B), (C), (4), is Pub. L. 101–336, July 26, 1990, 104 Stat. 327, which is classified principally to chapter 126 (§12101 et seq.) of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 12101 of Title 42 and Tables.

§ 1185n. Reporting on pharmacy benefits and drug costs

(a) In general

Not later than 1 year after December 27, 2020, and not later than June 1 of each year thereafter, a group health plan (or health insurance coverage offered in connection with such a plan) shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury the following information with respect to the health plan or coverage in the previous plan year:

(1) The beginning and end dates of the plan year.

(2) The number of participants and beneficiaries.

(3) Each State in which the plan or coverage is offered.

(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.

(5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.

(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.

(7) Total spending on health care services by such group health plan or health insurance coverage, broken down by—

(A) the type of costs, including—

(i) hospital costs;

(ii) health care provider and clinical service costs, for primary care and specialty care separately;

(iii) costs for prescription drugs; and

(iv) other medical costs, including wellness services; and

(B) spending on prescription drugs by—

(i) the health plan or coverage; and

(ii) the participants and beneficiaries.

(8) The average monthly premium—

(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

(B) paid by participants and beneficiaries.

(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan or coverage, including—

(A) the amounts so paid for each therapeutic class of drugs; and

(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year.

(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

(b) Report

Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of Labor, shall make available on the internet website of the Department of Labor a report on prescription drug reimbursements under group health plans (or health insurance coverage offered in connection with such a plan), prescription drug pricing trends, and the role of prescription drug costs in

contributing to premium increases or decreases under such plans or coverage, aggregated in such a way as no drug or plan specific information will be made public.

(c) Privacy protections

No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).

(Pub. L. 93–406, title I, § 725, as added Pub. L. 116–260, div. BB, title II, § 204(b), Dec. 27, 2020, 134 Stat. 2919.)

Subpart C—General Provisions

§ 1191. Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(b) Special rules in case of portability requirements

(1) In general

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 1181 of this title which differs from the standards or requirements specified in such section.

(2) Exceptions

Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(A) substitutes for the reference to ''6-month period'' in section 1181(a)(1) of this title a reference to any shorter period of time;

(B) substitutes for the reference to ''12 months'' and ''18 months'' in section 1181(a)(2) of this title a reference to any shorter period of time;

(C) substitutes for the references to ''63 days'' in sections 1181(c)(2)(A) and (d)(4)(A)[1] of this title a reference to any greater number of days;

(D) substitutes for the reference to ''30-day period'' in sections 1181(b)(2)[2] and (d)(1) of this title a reference to any greater period;

(E) prohibits the imposition of any preexisting condition exclusion in cases not described in section 1181(d) of this title or expands the exceptions described in such section;

(F) requires special enrollment periods in addition to those required under section 1181(f) of this title; or

(G) reduces the maximum period permitted in an affiliation period under section 1181(g)(1)(B)[3] of this title.

(c) Rules of construction

Except as provided in section 1185 of this title, nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions

For purposes of this section—

(1) State law

The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) State

The term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

(Pub. L. 93–406, title I, § 731, formerly § 704, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1946; renumbered § 731 and amended Pub. L. 104–204, title VI, § 603(a)(3), (b)(1), Sept. 26, 1996, 110 Stat. 2935, 2937.)

Editorial Notes

AMENDMENTS

1996—Subsec. (c). Pub. L. 104–204, § 603(b)(1), substituted ''Except as provided in section 1185 of this title, nothing'' for ''Nothing''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

[1] So in original. Section 1181(d)(4) of this title does not contain subpars.

[2] So in original. Section 1181(b)(2) of this title does not refer to a 30-day period.

[3] So in original. Probably should be ''1181(g)(1)(C)''.

§ 1191a. Special rules relating to group health plans

(a) General exception for certain small group health plans

The requirements of this part (other than section 1185 of this title) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for certain benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(1) of this title.

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(2) of this title if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 1191b(c)(3) of this title if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental excepted benefits

The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 1191b(c)(4) of this title if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Treatment of partnerships

For purposes of this part—

(1) Treatment as a group health plan

Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

(2) Employer

In the case of a group health plan, the term ''employer'' also includes the partnership in relation to any partner.

(3) Participants of group health plans

In the case of a group health plan, the term ''participant'' also includes—

(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

(Pub. L. 93–406, title I, § 732, formerly § 705, as added Pub. L. 104–191, title I, § 101(a), Aug. 21, 1996, 110 Stat. 1948; renumbered § 732 and amended Pub. L. 104–204, title VI, § 603(a)(3), (b)(2), (3)(I)–(L), Sept. 26, 1996, 110 Stat. 2935, 2937, 2938.)

Editorial Notes

AMENDMENTS

1996—Subsec. (a). Pub. L. 104–204, § 603(b)(2), inserted ''(other than section 1185 of this title)'' after ''part''.

Subsecs. (b), (c)(1) to (3). Pub. L. 104–204, § 603(b)(3)(I)–(L), made technical amendment to references in original act which appear in text as references to section 1191b of this title.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 1996 AMENDMENT

Amendment by Pub. L. 104–204 applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as a note under section 1003 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

§ 1191b. Definitions

(a) Group health plan

For purposes of this part—

(1) In general

The term ''group health plan'' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Such term shall not

include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).

(2) Medical care

The term ''medical care'' means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) Definitions relating to health insurance

For purposes of this part—

(1) Health insurance coverage

The term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) Health insurance issuer

The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 1144(b)(2) of this title). Such term does not include a group health plan.

(3) Health maintenance organization

The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) Group health insurance coverage

The term ''group health insurance coverage'' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) Excepted benefits

For purposes of this part, the term ''excepted benefits'' means benefits under one or more (or any combination thereof) of the following:

(1) Benefits not subject to requirements

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) Benefits not subject to requirements if offered separately

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Benefits not subject to requirements if offered as separate insurance policy

Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of title 42), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan.

(d) Other definitions

For purposes of this part—

(1) COBRA continuation provision

The term ''COBRA continuation provision'' means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of title 26, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.].

(2) Health status-related factor

The term ''health status-related factor'' means any of the factors described in section 1182(a)(1) of this title.

(3) Network plan

The term ''network plan'' means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) Placed for adoption

The term ''placement'', or being ''placed'', for adoption, has the meaning given such term in section 1169(c)(3)(B) of this title.

(5) Family member

The term ''family member'' means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 1181(f)(2) of this title) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) Genetic information

(A) In general

The term ''genetic information'' means, with respect to any individual, information about—

(i) such individual's genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) Inclusion of genetic services and participation in genetic research

Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) Exclusions

The term ''genetic information'' shall not include information about the sex or age of any individual.

(7) Genetic test

(A) In general

The term ''genetic test'' means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) Exceptions

The term ''genetic test'' does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) Genetic services

The term ''genetic services'' means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(9) Underwriting purposes

The term ''underwriting purposes'' means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(Pub. L. 93–406, title I, §733, formerly §706, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1949; renumbered §733, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935; amended Pub. L. 110–233, title I, §101(d), May 21, 2008, 122 Stat. 885; Pub. L. 114–255, div. C, title XVIII, §18001(b)(1), Dec. 13, 2016, 130 Stat. 1343.)

Editorial Notes

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (d)(1)(C), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXII of the Act is classified generally to subchapter XX (§300bb–1 et seq.) of chapter 6A of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 201 of Title 42 and Tables.

AMENDMENTS

2016—Subsec. (a)(1). Pub. L. 114–255 inserted at end ''Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of title 26).''

2008—Subsec. (d)(5) to (9). Pub. L. 110–233 added pars. (5) to (9).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to plan years beginning after Dec. 31, 2016, see section 18001(b)(3) of Pub. L. 114–255, set out as a note under section 1167 of this title.

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–233 applicable with respect to group health plans for plan years beginning after the date that is one year after May 21, 2008, see section 101(f)(2) of Pub. L. 110–233, set out as a note under section 1132 of this title.

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

§ 1191c. Regulations

The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.

(Pub. L. 93–406, title I, §734, formerly §707, as added Pub. L. 104–191, title I, §101(a), Aug. 21, 1996, 110 Stat. 1951; renumbered §734, Pub. L. 104–204, title VI, §603(a)(3), Sept. 26, 1996, 110 Stat. 2935.)

Editorial Notes

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably

means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, which is set out as a note under section 300gg–92 of Title 42, The Public Health and Welfare.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning after June 30, 1997, except as otherwise provided, see section 101(g) of Pub. L. 104–191, set out as a note under section 1181 of this title.

§ 1191d. Standardized reporting format

(a) In general

Not later than 1 year after December 27, 2020, the Secretary shall establish (and periodically update) a standardized reporting format for the voluntary reporting, by group health plans to State All Payer Claims Databases, of medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers, and shall provide guidance to States on the process by which States may collect such data from such plans in the standardized reporting format.

(b) Consultation

(1) Advisory Committee

Not later than 90 days after December 27, 2020, the Secretary shall convene an Advisory Committee (referred to in this section as the ''Committee''), consisting of 15 members to advise the Secretary regarding the format and guidance described in paragraph (1).[1]

(2) Membership

(A) Appointment

In accordance with subparagraph (B), not later than 90 days after December 27, 2020, the Secretary, in coordination with the Secretary of Health and Human Services, shall appoint under subparagraph (B)(iii), and the Comptroller General of the United States shall appoint under subparagraph (B)(iv), members who have distinguished themselves in the fields of health services research, health economics, health informatics, data privacy and security, or the governance of State All Payer Claims Databases, or who represent organizations likely to submit data to or use the database, including patients, employers, or employee organizations that sponsor group health plans, health care providers, health insurance issuers, or third-party administrators of group health plans. Such members shall serve 3-year terms on a staggered basis. Vacancies on the Committee shall be filled by appointment consistent with this paragraph not later than 3 months after the vacancy arises.

(B) Composition

The Committee shall be comprised of—

(i) the Assistant Secretary of Employee Benefits and Security Administration of the Department of Labor, or a designee of such Assistant Secretary;

(ii) the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, or a designee of such Assistant Secretary;

(iii) members appointed by the Secretary, in coordination with the Secretary of Health and Human Services, including—

(I) 1 member to serve as the chair of the Committee;

(II) 1 representative of the Centers for Medicare & Medicaid Services;

(III) 1 representative of the Agency for Healthcare Research and Quality;

(IV) 1 representative of the Office for Civil Rights of the Department of Health and Human Services with expertise in data privacy and security;

(V) 1 representative of the National Center for Health Statistics;

(VI) 1 representative of the Office of the National Coordinator for Health Information Technology; and

(VII) 1 representative of a State All-Payer[2] Claims Database;

(iv) members appointed by the Comptroller General of the United States, including—

(I) 1 representative of an employer that sponsors a group health plan;

(II) 1 representative of an employee organization that sponsors a group health plan;

(III) 1 academic researcher with expertise in health economics or health services research;

(IV) 1 consumer advocate; and

(V) 2 additional members.

(3) Report

Not later than 180 days after December 27, 2020, the Committee shall report to the Secretary, the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Energy and Commerce and the Committee on Education and Labor of the House of Representatives. Such report shall include recommendations on the establishment of the format and guidance described in subsection (a).

(c) State All Payer Claims Database

In this section, the term ''State All Payer Claims Database'' means, with respect to a State, a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files, which are collected from private and public payers.

(d) Authorization of appropriations

To carry out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2021, to remain available until expended or, if sooner, until the date described in subsection (e).

(e) Sunset

Beginning on the date on which the report is submitted under subsection (b)(3), subsection (b) shall have no force or effect.

(Pub. L. 93–406, title I, § 735, as added Pub. L. 116–260, div. BB, title I, § 115(b), Dec. 27, 2020, 134 Stat. 2877.)

[1] So in original. Probably should be ''subsection (a).''

[2] So in original. Definition in subsec. (c) does not contain hyphen in ''All Payer''.

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

Committee on Education and Labor of House of Representatives changed to Committee on Education and the Workforce of House of Representatives by House Resolution No. 5, One Hundred Eighteenth Congress, Jan. 9, 2023.

PART 8—PENSION-LINKED EMERGENCY SAVINGS ACCOUNTS

§ 1193. Pension-linked emergency savings accounts

(a) In general

A plan sponsor of an individual account plan may—

(1) include in such individual account plan a pension-linked emergency savings account meeting the requirements of subsection (c); and

(2)(A) offer to enroll an eligible participant in such pension-linked emergency savings account; or

(B) automatically enroll an eligible participant in such account pursuant to an automatic contribution arrangement described in paragraph (2) of subsection (c).

(b) Eligible participant

(1) In general

For purposes of this part, the term ''eligible participant'', with regard to an individual account plan, means an individual who—

(A) meets any age, service, and other eligibility requirements of the plan; and

(B) is not a highly compensated employee.

(2) Eligible participant who becomes a highly compensated employee

Notwithstanding paragraph (1)(B), an individual who is enrolled in a pension-linked emergency savings account and thereafter becomes a highly compensated employee may not make further contributions to such account, but retains the right to withdraw any account balance of such account in accordance with subsection (c)(1)(A)(ii).

(3) Definition

For purposes of this subsection, the term ''highly compensated employee'' has the meaning given the term in section 414(q) of title 26.

(c) Account requirements

(1) In general

A pension-linked emergency savings account—

(A) shall—

(i) not have a minimum contribution or account balance requirement;

(ii) allow for withdrawal by the participant of the account balance, in whole or in part at the discretion of the participant, at least once per calendar month and for distribution of such withdrawal to the participant as soon as practicable from the date on which the participant elects to make such withdrawal; and

(iii) be, as selected by the plan sponsor, held as cash, in an interest-bearing deposit account, or in an investment product—

(I) designed to—

(aa) maintain over the term of the investment, the dollar value that is equal to the amount invested in the product; and

(bb) preserve principal and provide a reasonable rate of return, whether or not such return is guaranteed, consistent with the need for liquidity; and

(II) offered by a State- or federally-regulated financial institution;

(B) may be subject to, as permitted by the Secretary, reasonable restrictions; and

(C)(i) may not, for not less than the first 4 withdrawals of funds from the account in a plan year, be subject to any fees or charges solely on the basis of such a withdrawal; and

(ii) may, for any subsequent withdrawal in a plan year, be subject to reasonable fees or charges in connection with such a withdrawal, including reasonable reimbursement fees imposed for the incidental costs of handling of paper checks.

(2) Establishment and termination of account

(A) Establishment of account

The pension-linked emergency savings account feature shall be included in the plan document of the individual account plan. Such individual account plan shall—

(i) separately account for contributions to the pension-linked emergency savings account of the individual account plan and any earnings properly allocable to the contributions;

(ii) maintain separate recordkeeping with respect to each such pension-linked emergency savings account; and

(iii) allow withdrawals from such account in accordance with section 402A(e)(7) of title 26.

(B) Termination of account

A plan sponsor may terminate the pension-linked emergency savings account feature of an individual account plan at any time.

(d) Account contributions

(1) Limitation

(A) In general

Subject to subparagraph (B), no contribution shall be accepted to a pension-linked emergency savings account to the extent such contribution would cause the portion of the account balance attributable to participant contributions to exceed the lesser of—

(i) $2,500; or

(ii) an amount determined by the plan sponsor of the pension-linked emergency savings account.

In the case of contributions made in taxable years beginning after December 31, 2024, the Secretary shall adjust the amount under clause (i) at the same time and in the same manner as the adjustment made by the Secretary of the Treasury under section 415(d) of title 26, except that the base period shall be the calendar quarter beginning July 1, 2023. Any increase under the preceding sentence which is not a multiple of $100 shall be rounded to the next lowest multiple of $100.