

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

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

#### REFERENCES IN TEXT

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

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

#### AMENDMENTS

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

#### EFFECTIVE DATE

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

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

#### (a) Clear accounting for costs

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

- (1) on reimbursement for clinical services provided to enrollees under such coverage;
- (2) for activities that improve health care quality; and
- (3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees.

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

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

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

###### (A) Requirement

Beginning not later than January 1, 2011, a health insurance issuer offering group or in-

dividual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subsection (a) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 18061, 18062, and 18063 of this title) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

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

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

#### (B) Rebate amount

##### (i) Calculation of amount

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

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

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

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

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

#### (2) Consideration in setting percentages

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

#### (3) Enforcement

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

<sup>2</sup>So in original. Probably should be "subsection (d).".

**(c) Definitions**

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

**(d) Adjustments**

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

**(e) Standard hospital charges**

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

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

## AMENDMENTS

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

## EFFECTIVE DATE

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

**§ 300gg-19. Appeals process****(a) Internal claims appeals****(1) In general**

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

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

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

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

coverage pending the outcome of the appeals process.

**(2) Established processes**

To comply with paragraph (1)—

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

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

**(b) External review**

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

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

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

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

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

**(c) Secretary authority**

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

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

## AMENDMENTS

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

## EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section