

**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 subpara-

graph (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 non-renewal 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.