

(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 cov-

erage, 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.

§ 1185l. 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 rule-making 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 asso-

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