

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).

(July 1, 1944, ch. 373, title XXVII, §2799A-10, as added Pub. L. 116-260, div. BB, title II, §204(a), Dec. 27, 2020, 134 Stat. 2918.)

PART E—HEALTH CARE PROVIDER
REQUIREMENTS

Statutory Notes and Related Subsidiaries

DEFINITIONS

For additional definitions applicable to this part, see section 300gg-111(a)(3) of this title.

§ 300gg-131. Balance billing in cases of emergency services

(a) In general

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the participant, beneficiary, or enrollee for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for such services (as determined in accordance with clauses (ii) and (iii) of section 300gg-111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable); and

(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing requirement for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 300gg-111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable).

(b) Definition

In this section, the term “visit” shall have such meaning as applied to such term for purposes of section 300gg-111(b) of this title.

(July 1, 1944, ch. 373, title XXVII, §2799B-1, as added Pub. L. 116-260, div. BB, title I, §104(a), Dec. 27, 2020, 134 Stat. 2824.)

§ 300gg-132. Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating facilities

(a) In general

Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 300gg-131 of this title applies) for which benefits are provided under the plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing requirement for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 300gg-111(b)(1) of this title¹ of section 9816(b)(1) of title 26, and of section 1185e(b)(1) of title 29, as applicable).

(b) Exception

(1) In general

Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (d).

(2) Ancillary services described

For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(3) Exception

The Secretary may, through rulemaking, establish a list (and update such list periodically) of advanced diagnostic laboratory tests,

¹ So in original. Probably should be followed by a comma.