

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.

which shall not be included as an ancillary service described in paragraph (2) and with respect to which subsection (a) would apply.

(c) Clarification

In the case of a nonparticipating provider that satisfies the notice and consent criteria of subsection (d) with respect to an item or service (referred to in this subsection as a “covered item or service”), such notice and consent criteria may not be construed as applying with respect to any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time such covered item or service is furnished. For purposes of the previous sentence, a covered item or service shall not include an ancillary service described in subsection (b)(2).

(d) Notice and consent to be treated by a nonparticipating provider or nonparticipating facility

(1) In general

A nonparticipating provider or nonparticipating facility satisfies the notice and consent criteria of this subsection, with respect to items or services furnished by the provider or facility 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 (or, if applicable, the participating health care facility on behalf of such provider) or nonparticipating facility—

(A) in the case that the participant, beneficiary, or enrollee makes an appointment to be furnished such items or services at least 72 hours prior to the date on which the individual is to be furnished such items or services, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) not later than 72 hours prior to the date on which the individual is furnished such items or services (or, in the case that the participant, beneficiary, or enrollee makes such an appointment within 72 hours of when such items or services are to be furnished, provides to the participant, beneficiary, or enrollee (or to an authorized representative of the participant, beneficiary, or enrollee) on such date the appointment is made), a written notice in paper or electronic form, as selected by the participant, beneficiary, or enrollee, (and including electronic notification, as practicable) specified by the Secretary, not later than July 1, 2021, through guidance (which shall be updated as determined necessary by the Secretary) that—

(i) contains the information required under paragraph (2);

(ii) clearly states that consent to receive such items and services from such nonparticipating provider or nonparticipating facility is optional and that the participant, beneficiary, or enrollee may instead seek care from a participating provider or at a participating facility, with respect to such plan or coverage, as applicable, in which case the cost-sharing responsibility

of the participant, beneficiary, or enrollee would not exceed such responsibility that would apply with respect to such an item or service that is furnished by a participating provider or participating facility, as applicable with respect to such plan; and

(iii) is available in the 15 most common languages in the geographic region of the applicable facility;

(B) obtains from the participant, beneficiary, or enrollee (or from such an authorized representative) the consent described in paragraph (3) to be treated by a nonparticipating provider or nonparticipating facility; and

(C) provides a signed copy of such consent to the participant, beneficiary, or enrollee through mail or email (as selected by the participant, beneficiary, or enrollee).

(2) Information required under written notice

For purposes of paragraph (1)(A)(i), the information described in this paragraph, with respect to a nonparticipating provider or nonparticipating facility and a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, is each of the following:

(A) Notification, as applicable, that the health care provider is a nonparticipating provider with respect to the health plan or the health care facility is a nonparticipating facility with respect to the health plan.

(B) Notification of the good faith estimated amount that such provider or facility may charge the participant, beneficiary, or enrollee for such items and services involved, including a notification that the provision of such estimate or consent to be treated under paragraph (3) does not constitute a contract with respect to the charges estimated for such items and services.

(C) In the case of a participating facility and a nonparticipating provider, a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.

(D) Information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility.

(3) Consent described to be treated by a nonparticipating provider or nonparticipating facility

For purposes of paragraph (1)(B), the consent described in this paragraph, with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer who is to be furnished items or services by a nonparticipating provider or nonparticipating facility, is a document specified by the Secretary, in consultation with the Secretary

of Labor, through guidance that shall be signed by the participant, beneficiary, or enrollee before such items or services are furnished and that—

(A) acknowledges (in clear and understandable language) that the participant, beneficiary, or enrollee has been—

(i) provided with the written notice under paragraph (1)(A);

(ii) informed that the payment of such charge by the participant, beneficiary, or enrollee may not accrue toward meeting any limitation that the plan or coverage places on cost-sharing, including an explanation that such payment may not apply to an in-network deductible applied under the plan or coverage; and

(iii) provided the opportunity to receive the written notice under paragraph (1)(A) in the form selected by the participant, beneficiary or enrollee; and

(B) documents the date on which the participant, beneficiary, or enrollee received the written notice under paragraph (1)(A) and the date on which the individual signed such consent to be furnished such items or services by such provider or facility.

(4) Rule of construction

The consent described in paragraph (3), with respect to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, shall constitute only consent to the receipt of the information provided pursuant to this subsection and shall not constitute a contractual agreement of the participant, beneficiary, or enrollee to any estimated charge or amount included in such information.

(e) Retention of certain documents

A nonparticipating facility (with respect to such facility or any nonparticipating provider at such facility) or a participating facility (with respect to nonparticipating providers at such facility) that obtains from a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer (or an authorized representative of such participant, beneficiary, or enrollee) a written notice in accordance with subsection (d)(1)(B), with respect to furnishing an item or service to such participant, beneficiary, or enrollee, shall retain such notice for at least a 7-year period after the date on which such item or service is so furnished.

(f) Definitions

In this section:

(1) The terms “nonparticipating provider” and “participating provider” have the meanings given such terms, respectively, in subsection (a)(3) of section 300gg-111 of this title.

(2) The term “participating health care facility” has the meaning given such term in subsection (b)(2) of section 300gg-111 of this title.

(3) The term “nonparticipating facility” means—

(A) with respect to emergency services (as defined in section 300gg-111(a)(3)(C)(i) of this

title) and a group health plan or group or individual 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 with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services described in section 300gg-111(a)(3)(C)(ii) of this title and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that does not have a contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(4) The term “participating facility” means—

(A) with respect to emergency services (as defined in clause (i) of section 300gg-111(a)(3)(C) of this title) that are not described in clause (ii) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a direct or indirect contractual relationship with the plan or issuer, respectively, with respect to the furnishing of such services under the plan or coverage, respectively; and

(B) with respect to services that pursuant to clause (ii) of section 300gg-111(a)(3)(C) of this title, of section 9816(a)(3) of title 26, and of section 1185e(a)(3) of title 29, as applicable are included as emergency services (as defined in clause (i) of such section and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a hospital or an independent freestanding emergency department, that has a contractual relationship with the plan or coverage, respectively, with respect to the furnishing of such services under the plan or coverage, respectively.

(July 1, 1944, ch. 373, title XXVII, §2799B-2, as added Pub. L. 116-260, div. BB, title I, §104(a), Dec. 27, 2020, 134 Stat. 2824.)

§ 300gg-133. Provider requirements with respect to disclosure on patient protections against balance billing

Beginning not later than January 1, 2022, each health care provider and health care facility shall make publicly available, and (if applicable) post on a public website of such provider or facility and provide to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer a one-page notice (either postal or electronic mail, as specified by the participant, beneficiary, or enrollee) in clear and understandable language containing information on—

(1) the requirements and prohibitions of such provider or facility under sections 300gg-131