(e) Preemption

The standards developed under subsection (a) shall preempt any related State standards that require a summary of benefits and coverage that provides less information to consumers than that required to be provided under this section, as determined by the Secretary.

(f) Failure to provide

An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) Development of standard definitions

(1) In general

The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance-related terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) Insurance-related terms

The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(3) Medical terms

The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(July 1, 1944, ch. 373, title XXVII, § 2715, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(b), Mar. 23, 2010, 124 Stat. 132, 884.)

Editorial Notes

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, § 10101(b), substituted ''and providing to applicants, enrollees, and policyholders or certificate holders'' for ''and providing to enrollees''.

Statutory Notes and Related Subsidiaries

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–15a. Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

(July 1, 1944, ch. 373, title XXVII, § 2715A, as added Pub. L. 111–148, title X, § 10101(c), Mar. 23, 2010, 124 Stat. 884.)

§ 300gg–16. Prohibition on discrimination in favor of highly compensated individuals

(a) In general

A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of title 26 (relating to prohibition on discrimination in favor of highly compensated individuals).

(b) Rules and definitions

For purposes of this section—

(1) Certain rules to apply

Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of title 26 shall apply.

(2) Highly compensated individual

The term ''highly compensated individual'' has the meaning given such term by section 105(h)(5) of title 26.

(July 1, 1944, ch. 373, title XXVII, § 2716, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(d), Mar. 23, 2010, 124 Stat. 135, 884.)

Editorial Notes

AMENDMENTS

2010—Pub. L. 111–148, § 10101(d), amended section generally. Prior to amendment, text read as follows:

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.''

Statutory Notes and Related Subsidiaries

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–17. Ensuring the quality of care

(a) Quality reporting

(1) In general

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in