18061, 18062, and 18063 of this title) for such plan year.

(ii) Calculation based on average ratio

Beginning on January 1, 2014, the determination made under subparagraph (A) for the year involved shall be based on the averages of the premiums expended on the costs described in such subparagraph and total premium revenue for each of the previous 3 years for the plan.

(2) Consideration in setting percentages

In determining the percentages under paragraph (1), a State shall seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

(3) Enforcement

The Secretary shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties.

(c) Definitions

Not later than December 31, 2010, and subject to the certification of the Secretary, the National Association of Insurance Commissioners shall establish uniform definitions of the activities reported under subsection (a) and standardized methodologies for calculating measures of such activities, including definitions of which activities, and in what regard such activities, constitute activities described in subsection (a)(2). Such methodologies shall be designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans.

(d) Adjustments

The Secretary may adjust the rates described in subsection (b) if the Secretary determines appropriate on account of the volatility of the individual market due to the establishment of State Exchanges.

(e) Standard hospital charges

Each hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1395ww(d)(4) of this title.

(July 1, 1944, ch. 373, title XXVII, §2718, as added and amended Pub. L. 111–148, title I, §1001(5), title X, §10101(f), Mar. 23, 2010, 124 Stat. 136, 885.)

Editorial Notes

AMENDMENTS

2010—Pub. L. 111–148, §10101(f), amended section generally. Prior to amendment, the section related to clear accounting for costs, ensuring that consumers receive value for premiums, standard hospital charges, and definitions.

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–19. Appeals process

(a) Internal claims appeals

(1) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—

(A) have in effect an internal claims appeal process;

(B) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman established under section 300gg–93 of this title to assist such enrollees with the appeals processes; and

(C) allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

(2) Established processes

To comply with paragraph (1)—

(A) a group health plan and a health insurance issuer offering group health coverage shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth at section 2560.503–1 of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

(B) a health insurance issuer offering individual health coverage, and any other issuer not subject to subparagraph (A), shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on March 23, 2010), and shall update such process in accordance with any standards established by the Secretary of Health and Human Services for such issuers.

(b) External review

A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).

(c) Secretary authority

The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, to be in compliance with the applicable process established under subsection (b), as determined appropriate by the Secretary.

(July 1, 1944, ch. 373, title XXVII, § 2719, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(g), Mar. 23, 2010, 124 Stat. 137, 887.)

Editorial Notes

AMENDMENTS

2010—Pub. L. 111–148, § 10101(g), amended section generally. Prior to amendment, section related to implementation of appeals process by group health plans and health insurance issuers.

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.

CONSUMER PROTECTIONS THROUGH APPLICATION OF HEALTH PLAN EXTERNAL REVIEW IN CASES OF CERTAIN SURPRISE MEDICAL BILLS

Pub. L. 116–260, div. BB, title I, § 110, Dec. 27, 2020, 134 Stat. 2861, provided that:

''(a) IN GENERAL.—In applying the provisions of section 2719(b) of the Public Health Service Act (42 U.S.C. 300gg–19(b)) to group health plans and health insurance issuers offering group or individual health insurance coverage, the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury, shall require, beginning not later than January 1, 2022, the external review process described in paragraph (1) of such section to apply with respect to any adverse determination by such a plan or issuer under section 2799A–1 or 2799A–2 [probably means section 2799A–1 or 2799A–2 of the Public Health Service Act, 42 U.S.C. 300gg–111, 300gg–112], section 716 or 717 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1185e, 1185f], or section 9816 or 9817 of the Internal Revenue Code of 1986 [26 U.S.C. 9816, 9817], including with respect to whether an item or service that is the subject to such a determination is an item or service to which such respective section applies.

''(b) DEFINITIONS.—The terms 'group health plan'; 'health insurance issuer'; 'group health insurance coverage', and 'individual health insurance coverage' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91), section 733 of the Employee Retirement Income Security Act (29 U.S.C. 1191b), and section 9832 of the Internal Revenue Code [26 U.S.C. 9832], as applicable.''

§ 300gg–19a. Patient protections

(a) Choice of health care professional

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance issuer,[1] provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization; or

(ii)(I) such services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;[2]

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701[3] of this Act, section 1181 of title 29, or section 9801 of title 26, and other than applicable cost-sharing).

(2) Definitions

In this subsection:

(A) Emergency medical condition

The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1395dd(e)(1)(A) of this title.

[1] So in original. Probably should be ''coverage,''.

[2] So in original. The word ''and'' probably should appear.

[3] See References in Text note below.