(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.

(B) Emergency services

The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1395dd of this title) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1395dd of this title to stabilize the patient.

(C) Stabilize

The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give[4] in section 1395dd(e)(3) of this title.

(c) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer in the group or individual market, 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.

(d) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group or individual health insurance coverage, 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, beneficiary, or enrollee 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 or individual 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, beneficiary, or enrollee 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.

(e) Application

The provisions of this section shall not apply with respect to a group health plan, health insurance issuers, or group or individual health insurance coverage with respect to plan years beginning on or on[5] January 1, 2022.

(July 1, 1944, ch. 373, title XXVII, §2719A, as added Pub. L. 111–148, title X, §10101(h), Mar. 23, 2010, 124 Stat. 888; amended Pub. L. 116–260, div. BB, title I, §102(a)(3)(A), Dec. 27, 2020, 134 Stat. 2771.)

Editorial Notes

REFERENCES IN TEXT

Section 2701 of this Act, referred to in subsec. (b)(1)(D), is a reference to section 2701 of act July 1, 1944. Section 2701, which was classified to section 300gg of this title, was renumbered section 2704, effective for plan years beginning on or after Jan. 1, 2014, with certain exceptions, and amended, by Pub. L. 111–148, title I, §§1201(2), 1563(c)(1), formerly §1562(c)(1), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 154, 264, 911, and was transferred to section 300gg–3 of this title. A new section 2701 of act July 1, 1944, related to fair health insurance premiums, was added, effective for plan years beginning on or after Jan. 1, 2014, and amended, by Pub. L. 111–148, title I, §1201(4), title X, §10103(a), Mar. 23, 2010, 124 Stat. 155, 892, and is classified to section 300gg of this title.

CODIFICATION

Pub. L. 111–148, which directed amendment of subpart II of part A of ''title XVIII'' of act July 1, 1944, by inserting section 2719A after section 2719, was executed by making the insertion in subpart II of part A of title XXVII of the Act, to reflect the probable intent of Congress.

[4] So in original. Probably should be ''given''.

[5] So in original.

AMENDMENTS

2020—Subsec. (e). Pub. L. 116–260 added subsec. (e).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2020 AMENDMENT

Amendment by Pub. L. 116–260 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 a note under section 8902 of Title 5, Government Organization and Employees.

§ 300gg–19b. Information on prescription drugs

(a) In general

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

(1) not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug to an enrollee in the plan or coverage from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage; and

(2) ensure that any entity that provides pharmacy benefits management services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing (or penalize such pharmacy for informing) an enrollee of any differential between the enrollee's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

(b) Definition

For purposes of this section, the term ''out-of-pocket cost'', with respect to acquisition of a drug, means the amount to be paid by the enrollee under the plan or coverage, including any cost-sharing (including any deductible, copayment, or coinsurance) and, as determined by the Secretary, any other expenditure.

(July 1, 1944, ch. 373, title XXVII, § 2729, as added Pub. L. 115–263, § 2, Oct. 10, 2018, 132 Stat. 3672.)

SUBPART 2—EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

Editorial Notes

CODIFICATION

This subpart 2 designation and heading was transferred along with sections 300gg–21 to 300gg–23 of this title to appear before section 300gg–25 of this title to reflect the renumbering of the sections in the original act by Pub. L. 111–148, title I, §§ 1001(4), 1563(c)(12)(D), (13)(C), (14)(B), formerly § 1562(c)(12)(D), (13)(C), (14)(B), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 269, 911.

Pub. L. 111–148, title I, § 1563(c)(11), formerly § 1562(c)(11), title X, § 10107(b)(1), Mar. 23, 2010, 124 Stat. 268, 911, redesignated subpart 4 as subpart 2.

Pub. L. 104–204, title VI, § 604(a)(2), Sept. 26, 1996, 110 Stat. 2939, redesignated subpart 3 as 4.

§ 300gg–21. Exclusion of certain plans

(a) Limitation on application of provisions relating to group health plans

(1) In general

The requirements of subparts 1 and 2[1] and part D shall apply with respect to group health plans only—

(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

(2) Treatment of non-Federal governmental plans

(A) Election to be excluded

Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2[1] otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

(B) Period of election

An election under subparagraph (A) shall apply—

(i) for a single specified plan year, or

(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

(C) Notice to enrollees

Under such an election, the plan shall provide for—

(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).[1]

(D) Election not applicable to requirements concerning genetic information

The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (a)(1)(F), (b)(3), (c), and (d) of section 2702[1] and the provisions of sections 2701[1] and 2702(b)[1] to the extent that such provisions apply to genetic information.

(E) Election not applicable

The election described in subparagraph (A) shall not be available with respect to the provisions of subparts I and II.

[1] See References in Text note below.