Editorial Notes

REFERENCES IN TEXT

Section 104 of the Health Care Portability and Accountability Act of 1996, referred to in text, probably means section 104 of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, set out below.

Statutory Notes and Related Subsidiaries

ASSURING COORDINATION AMONG DEPARTMENTS OF TREASURY, HEALTH AND HUMAN SERVICES, AND LABOR

Pub. L. 104–191, title I, §104, Aug. 21, 1996, 110 Stat. 1978, provided that: ''The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle [subtitle A (§§101–104) of title I of Pub. L. 104–191, enacting this section, sections 300gg, 300gg–1, 300gg–11 to 300gg–13, 300gg–21 to 300gg–23, and 300gg–91 of this title, and sections 1181 to 1183 and 1191 to 1191c of Title 29, Labor, amending sections 300e and 300bb–8 of this title and sections 1003, 1021, 1022, 1024, 1132, 1136, and 1144 of Title 29, and enacting provisions set out as notes under section 300gg of this title and section 1181 of Title 29] (and the amendments made by this subtitle and section 401 [enacting sections 9801 to 9806 of Title 26, Internal Revenue Code]) are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''

§ 300gg–93. Health insurance consumer information

(a) In general

The Secretary shall award grants to States to enable such States (or the Exchanges operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

(2) health insurance ombudsman programs.

(b) Eligibility

(1) In general

To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

(2) Criteria

A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) Duties

The office of health insurance consumer assistance or health insurance ombudsman shall—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process;

(2) collect, track, and quantify problems and inquiries encountered by consumers;

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;

(4) assist consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and

(5) resolve problems with obtaining premium tax credits under section 36B of title 26.

(d) Data collection

As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

(e) Funding

(1) Initial funding

There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

(2) Authorization for subsequent years

There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

(July 1, 1944, ch. 373, title XXVII, §2793, as added Pub. L. 111–148, title I, §1002, Mar. 23, 2010, 124 Stat. 138.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for fiscal years beginning with fiscal year 2010, see section 1004(a) of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

Section effective Mar. 23, 2010, see section 1004(b) of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

§ 300gg–94. Ensuring that consumers get value for their dollars

(a) Initial premium review process

(1) In general

The Secretary, in conjunction with States, shall establish a process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

(2) Justification and disclosure

The process established under paragraph (1) shall require health insurance issuers to sub-

mit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such information on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and justifications for all health insurance issuers.

(b) Continuing premium review process

(1) Informing Secretary of premium increase patterns

As a condition of receiving a grant under subsection (c)(1), a State, through its Commissioner of Insurance, shall—

(A) provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the State; and

(B) make recommendations, as appropriate, to the State Exchange about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern or practice of excessive or unjustified premium increases.

(2) Monitoring by Secretary of premium increases

(A) In general

Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

(B) Consideration in opening Exchange

In determining under section 18032(f)(2)(B) of this title whether to offer qualified health plans in the large group market through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(c) Grants in support of process

(1) Premium review grants during 2010 through 2014

The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

(A) in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage;

(B) in providing information and recommendations to the Secretary under subsection (b)(1); and

(C) in establishing centers (consistent with subsection (d)) at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make such information available to such issuers, health care providers, health researchers, health care policy makers, and the general public.

(2) Funding

(A) In general

Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000, to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(B) Further availability for insurance reform and consumer protection

If the amounts appropriated under subparagraph (A) are not fully obligated under grants under paragraph (1) by the end of fiscal year 2014, any remaining funds shall remain available to the Secretary for grants to States for planning and implementing the insurance reforms and consumer protections under part A.

(C) Allocation

The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection. Under such formula—

(i) the Secretary shall consider the number of plans of health insurance coverage offered in each State and the population of the State; and

(ii) no State qualifying for a grant under paragraph (1) shall receive less than $1,000,000, or more than $5,000,000 for a grant year.

(3) Parity implementation

(A) In general

Beginning during the first fiscal year that begins after December 29, 2022, the Secretary shall, out of funds made available pursuant to subparagraph (C), award grants to eligible States to enforce and ensure compliance with the mental health and substance use disorder parity provisions of section 300gg–26 of this title.

(B) Eligible State

A State shall be eligible for a grant awarded under this paragraph only if such State—

(i) submits to the Secretary an application for such grant at such time, in such manner, and containing such information as specified by the Secretary; and

(ii) agrees to request and review from health insurance issuers offering group or individual health insurance coverage the comparative analyses and other information required of such health insurance issuers under subsection (a)(8)(A) of section 300gg–26 of this title relating to the design and application of nonquantitative treatment limitations imposed on mental health or substance use disorder benefits.

(C) Authorization of appropriations

There are authorized to be appropriated $10,000,000 for each of the first five fiscal years beginning after December 29, 2022, to remain available until expended, for purposes of awarding grants under subparagraph (A).

(d) Medical reimbursement data centers

(1) Functions

A center established under subsection (c)(1)(C) shall—

(A) develop fee schedules and other database tools that fairly and accurately reflect

market rates for medical services and the geographic differences in those rates;

(B) use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;

(C) regularly update such fee schedules and other database tools to reflect changes in charges for medical services;

(D) make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

(E) regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

(2) Conflicts of interest

A center established under subsection (c)(1)(C) shall adopt by-laws that ensures that the center (and all members of the governing board of the center) is independent and free from all conflicts of interest. Such by-laws shall ensure that the center is not controlled or influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs.

(3) Rule of construction

Nothing in this subsection shall be construed to permit a center established under subsection (c)(1)(C) to compel health insurance issuers to provide data to the center.

(July 1, 1944, ch. 373, title XXVII, § 2794, as added and amended Pub. L. 111–148, title I, § 1003, title X, § 10101(i), Mar. 23, 2010, 124 Stat. 139, 891; Pub. L. 117–328, div. FF, title I, § 1331(a), Dec. 29, 2022, 136 Stat. 5698.)

Editorial Notes

PRIOR PROVISIONS

A prior section 2794 of act July 1, 1944, was renumbered section 2795 and is classified to section 300gg–95 of this title.

AMENDMENTS

2022—Subsec. (c)(3). Pub. L. 117–328 added par. (3).

2010—Subsec. (c)(1)(C). Pub. L. 111–148, § 10101(i)(1), added subpar. (C).

Subsec. (d). Pub. L. 111–148, § 10101(i)(2), added subsec. (d).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section effective for fiscal years beginning with fiscal year 2010, see section 1004(a) of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

Section effective Mar. 23, 2010, see section 1004(b) of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

§ 300gg–95. Uniform fraud and abuse referral format

The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer[1] seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.

(July 1, 1944, ch. 373, title XXVII, § 2795, formerly § 2794, as added Pub. L. 111–148, title VI, § 6603, Mar. 23, 2010, 124 Stat. 780; renumbered § 2795, Pub. L. 117–328, div. FF, title I, § 1331(b), Dec. 29, 2022, 136 Stat. 5698.)

PART D—ADDITIONAL COVERAGE PROVISIONS

§ 300gg–111. Preventing surprise medical bills

(a) Coverage of emergency services

(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

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

(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

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

(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

(iv) the group health plan or health insurance issuer, respectively—

(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an ini-

[1] So in original. Probably should be ''issuers''.