United States Code Annotated
Title 29. Labor
Chapter 18. Employee Retirement Income Security Program (Refs & Annos)
Subchapter I. Protection of Employee Benefit Rights (Refs & Annos)
Subtitle B. Regulatory Provisions
Part 7. Group Health Plan Requirements
Subpart B. Other Requirements

29 U.S.C.A. § 1185i

§ 1185i. Protecting patients and improving the accuracy of provider directory information

Effective: December 27, 2020
Currentness

(a) Provider directory information requirements

(1) In general

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall--

(A) establish the verification process described in paragraph (2);

(B) establish the response protocol described in paragraph (3);

(C) establish the database described in paragraph (4); and

(D) include in any directory (other than the database described in subparagraph (C)) containing provider directory information with respect to such plan or such coverage the information described in paragraph (5).

(2) Verification process

The verification process described in this paragraph is, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, a process--

(A) under which, not less frequently than once every 90 days, such plan or such issuer (as applicable) verifies and updates the provider directory information included on the database described in paragraph (4) of such plan or issuer of each health care provider and health care facility included in such database;

(B) that establishes a procedure for the removal of such a provider or facility with respect to which such plan or issuer has been unable to verify such information during a period specified by the plan or issuer; and

(C) that provides for the update of such database within 2 business days of such plan or issuer receiving from such a provider or facility information pursuant to section 300gg-139 of Title 42.

(3) Response protocol

The response protocol described in this paragraph is, in the case of an individual enrolled under a group health plan or group health insurance coverage offered by a health insurance issuer who requests information through a telephone call or electronic, web-based, or Internet-based means on whether a health care provider or health care facility has a contractual relationship to furnish items and services under such plan or such coverage, a protocol under which such plan or such issuer (as applicable), in the case such request is made through a telephone call--

(A) responds to such individual as soon as practicable and in no case later than 1 business day after such call is received, through a written electronic or print (as requested by such individual) communication; and

(B) retains such communication in such individual's file for at least 2 years following such response.

(4) Database

The database described in this paragraph is, with respect to a group health plan or health insurance issuer offering group health insurance coverage, a database on the public website of such plan or issuer that contains--

(A) a list of each health care provider and health care facility with which such plan or such issuer has a direct or indirect contractual relationship for furnishing items and services under such plan or such coverage; and

(B) provider directory information with respect to each such provider and facility.

(5) Information

The information described in this paragraph is, with respect to a print directory containing provider directory information with respect to a group health plan or group health insurance coverage offered by a health insurance issuer, a notification that such information contained in such directory was accurate as of the date of publication of such directory and that an individual enrolled under such plan or such coverage should consult the database described in paragraph (4) with respect to such plan or such coverage or contact such plan or the issuer of such coverage to obtain the most current provider directory information with respect to such plan or such coverage.

(6) Definition

For purposes of this subsection, the term “provider directory information” includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital

contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

(7) Rule of construction

Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories, to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of this title.

(b) Cost-sharing for services provided based on reliance on incorrect provider network information

(1) In general

For plan years beginning on or after January 1, 2022, in the case of an item or service furnished to a participant or beneficiary of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, if such item or service would otherwise be covered under such plan or coverage if furnished by a participating provider or participating facility and if either of the criteria described in paragraph (2) applies with respect to such participant or beneficiary and item or service, the plan or coverage--

(A) shall not impose on such participant or beneficiary a cost-sharing amount for such item or service so furnished that is greater than the cost-sharing amount that would apply under such plan or coverage had such item or service been furnished by a participating provider; and

(B) shall apply the deductible or out-of-pocket maximum, if any, that would apply if such services were furnished by a participating provider or a participating facility.

(2) Criteria described

For purposes of paragraph (1), the criteria described in this paragraph, with respect to an item or service furnished to a participant or beneficiary of a group health plan or group health insurance coverage offered by a health insurance issuer by a nonparticipating provider or a nonparticipating facility, are the following:

(A) The participant or beneficiary received through a database, provider directory, or response protocol described in subsection (a) information with respect to such item and service to be furnished and such information provided that the provider was a participating provider or facility was a participating facility, with respect to the plan for furnishing such item or service.

(B) The information was not provided, in accordance with subsection (a), to the participant or beneficiary and the participant or beneficiary requested through the response protocol described in subsection (a)(3) of the plan or coverage information on whether the provider was a participating provider or facility was a participating facility with respect to the plan for furnishing such item or service and was informed through such protocol that the provider was such a participating provider or facility was such a participating facility.

(c) Disclosure on patient protections against balance billing

For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 1185e of this title applies--

(1) information in plain language on--

(A) the requirements and prohibitions applied under sections 300gg-131 and 300gg-132 of Title 42 (relating to prohibitions on balance billing in certain circumstances);

(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant or beneficiary of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant or beneficiary; and

(C) the requirements applied under section 1185e of this title; and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

CREDIT(S)

(Pub.L. 93-406, Title I, § 720, as added Pub.L. 116-260, Div. BB, Title I, § 116(b), Dec. 27, 2020, 134 Stat. 2881.)

29 U.S.C.A. § 1185i, 29 USCA § 1185i
Current through PL 117-1 with the exception of PL 116-283 and PL 116-315. Incorporation of changes from PL 116-283 and PL 116-315 are in progress. Refer to statute section credits for more details.

End of Document