gram, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

(C) Whether the transport in which the services were furnished originated in a rural or urban area.

(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

(2) Such other information regarding providers of air ambulance services as the Secretary may specify.

(Added Pub. L. 116–260, div. BB, title I, § 106(b)(3)(A), Dec. 27, 2020, 134 Stat. 2854.)

Editorial Notes

REFERENCES IN TEXT

Section 106(d) of the No Surprises Act, referred to in subsec. (a)(1), is section 106(d) of div. BB of Pub. L. 116–260, which is set out as a note under section 300gg–118 of Title 42, The Public Health and Welfare.

§ 9824. Increasing transparency by removing gag clauses on price and quality information

(a) [1] Increasing price and quality transparency for plan sponsors and consumers

(1) In general

A group health plan may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(2) Clarification regarding public disclosure of information

Nothing in paragraph (1)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraph (1).

(3) Attestation

A group health plan shall annually submit to the Secretary an attestation that such plan is in compliance with the requirements of this subsection.

(4) Rules of construction

Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan or plan sponsor to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

(Added Pub. L. 116–260, div. BB, title II, § 201(c), Dec. 27, 2020, 134 Stat. 2893.)

Editorial Notes

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(1)(B), (C), (4), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of Title 42, The Public Health and Welfare.

The Genetic Information Nondiscrimination Act of 2008, referred to in subsec. (a)(1)(B), (C), (4), is Pub. L. 110–233, May 21, 2008, 122 Stat. 881. For complete classification of this Act to the Code, see Short Title note set out under section 2000ff of Title 42, The Public Health and Welfare, and Tables.

The Americans with Disabilities Act of 1990, referred to in subsec. (a)(1)(B), (C), (4), is Pub. L. 101–336, July 26, 1990, 104 Stat. 327, which is classified principally to chapter 126 (§ 12101 et seq.) of Title 42, The Public Health and Welfare. For complete classification of this Act to the Code, see Short Title note set out under section 12101 of Title 42 and Tables.

§ 9825. Reporting on pharmacy benefits and drug costs

(a) In general

Not later than 1 year after the date of enactment of the Consolidated Appropriations Act, 2021, and not later than June 1 of each year

[1] So in original. There is no subsec. (b).

thereafter, a group health plan shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor the following information with respect to the health plan in the previous plan year:

(1) The beginning and end dates of the plan year.

(2) The number of participants and beneficiaries.

(3) Each State in which the plan is offered.

(4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each such drug.

(5) The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug.

(6) The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan in each such plan year.

(7) Total spending on health care services by such group health plan, broken down by—

(A) the type of costs, including—

(i) hospital costs;

(ii) health care provider and clinical service costs, for primary care and specialty care separately;

(iii) costs for prescription drugs; and

(iv) other medical costs, including wellness services; and

(B) spending on prescription drugs by—

(i) the health plan; and

(ii) the participants and beneficiaries.

(8) The average monthly premium—

(A) paid by employers on behalf of participants and beneficiaries, as applicable; and

(B) paid by participants and beneficiaries.

(9) Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan, including—

(A) the amounts so paid for each therapeutic class of drugs; and

(B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year.

(10) Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph (9).

(b) Report

Not later than 18 months after the date on which the first report is required under subsection (a) and biannually thereafter, the Secretary, acting in coordination with the Inspector General of the Department of the Treasury, shall make available on the internet website of the Department of the Treasury a report on prescription drug reimbursements under group health plans, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans, aggregated in such a way as no drug or plan specific information will be made public.

(c) Privacy protections

No confidential or trade secret information submitted to the Secretary under subsection (a) shall be included in the report under subsection (b).

(Added Pub. L. 116–260, div. BB, title II, § 204(c), Dec. 27, 2020, 134 Stat. 2920.)

Editorial Notes

REFERENCES IN TEXT

The date of enactment of the Consolidated Appropriations Act, 2021, referred to in subsec. (a), is the date of enactment of Pub. L. 116–260, which was approved Dec. 27, 2020.

Subchapter C—General Provisions

Editorial Notes

AMENDMENTS

2008—Pub. L. 110–233, title I, § 103(e)(2), May 21, 2008, 122 Stat. 899, added item 9834.

1997—Pub. L. 105–34, title XV, § 1531(a)(3), Aug. 5, 1997, 111 Stat. 1081, added subchapter heading and analysis.

§ 9831. General exceptions

(a) Exception for certain plans

The requirements of this chapter shall not apply to—

(1) any governmental plan, and

(2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) Exception for certain benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(1).

(c) Exception for certain benefits if certain conditions met

(1) Limited, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(2) if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) Noncoordinated, excepted benefits

The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.