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.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) Supplemental 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)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) Exception for qualified small employer health reimbursement arrangements

(1) In general

For purposes of this title (and notwithstanding any other provision of this title), the term ''group health plan'' shall not include any qualified small employer health reimbursement arrangement.

(2) Qualified small employer health reimbursement arrangement

For purposes of this subsection—

(A) In general

The term ''qualified small employer health reimbursement arrangement'' means an arrangement which—

(i) is described in subparagraph (B), and

(ii) is provided on the same terms to all eligible employees of the eligible employer.

(B) Arrangement described

An arrangement is described in this subparagraph if—

(i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,

(ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement), and

(iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed $4,950 ($10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

(C) Certain variation permitted

For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee's permitted benefit under such arrangement varies in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

(i) the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee's family members, the age of such family members), or

(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

(D) Rules relating to maximum dollar limitation

(i) Amount prorated in certain cases

In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (B)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (B)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

(ii) Inflation adjustment

In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (B)(iii) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ''calendar year 2015'' for ''calendar year 2016'' in subparagraph (A)(ii) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of $50, such dollar amount shall be rounded to the next lowest multiple of $50.

(3) Other definitions

For purposes of this subsection—

(A) Eligible employee

The term ''eligible employee'' means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting ''90 days'' for ''3 years'' in clause (i) thereof).

(B) Eligible employer

The term ''eligible employer'' means an employer that—

(i) is not an applicable large employer as defined in section 4980H(c)(2), and

(ii) does not offer a group health plan to any of its employees.

(C) Permitted benefit

The term ''permitted benefit'' means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health

reimbursement arrangement for the year with respect to such employee.

(4) Notice

(A) In general

An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible), provide a written notice to each eligible employee which includes the information described in subparagraph (B).

(B) Contents of notice

The notice required under subparagraph (A) shall include each of the following:

(i) A statement of the amount which would be such eligible employee's permitted benefit under the arrangement for the year.

(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.

(Added Pub. L. 104–191, title IV, § 401(a), Aug. 21, 1996, 110 Stat. 2080, § 9804; renumbered § 9831 and amended Pub. L. 105–34, title XV, § 1531(a)(2), (b)(1)(B)–(E), Aug. 5, 1997, 111 Stat. 1081, 1084, 1085; Pub. L. 114–255, div. C, title XVIII, § 18001(a)(1), Dec. 13, 2016, 130 Stat. 1338; Pub. L. 115–97, title I, § 11002(d)(1)(TT), Dec. 22, 2017, 131 Stat. 2061; Pub. L. 116–94, div. N, title I, § 503(b)(2), Dec. 20, 2019, 133 Stat. 3119.)

INFLATION ADJUSTED ITEMS FOR CERTAIN YEARS

For inflation adjustment of certain items in this section, see Revenue Procedures listed in a table under section 1 of this title.

Editorial Notes

AMENDMENTS

2019—Subsec. (d)(1). Pub. L. 116–94 struck out ''except as provided in section 4980I(f)(4)'' before ''and notwithstanding any other provision of this title''.

2017—Subsec. (d)(2)(D)(ii)(II). Pub. L. 115–97 substituted ''for 'calendar year 2016' in subparagraph (A)(ii)'' for ''for 'calendar year 1992' in subparagraph (B)''.

2016—Subsec. (d). Pub. L. 114–255 added subsec. (d).

1997—Pub. L. 105–34 renumbered section 9804 of this title as this section and substituted reference to section 9832 of this title for reference to section 9805 of this title in subsecs. (b) and (c)(1) to (3).

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2019 AMENDMENT

Amendment by Pub. L. 116–94 applicable to taxable years beginning after Dec. 31, 2019, see section 503(c) of Pub. L. 116–94, set out as a note under section 6051 of this title.

EFFECTIVE DATE OF 2017 AMENDMENT

Amendment by Pub. L. 115–97 applicable to taxable years beginning after Dec. 31, 2017, see section 11002(e) of Pub. L. 115–97, set out as a note under section 1 of this title.

EFFECTIVE DATE OF 2016 AMENDMENT

Amendment by Pub. L. 114–255 applicable to years beginning after Dec. 31, 2016, see section 18001(a)(7) of Pub. L. 114–255, set out as a note under section 36B of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by Pub. L. 105–34 applicable with respect to group health plans for plan years beginning on or after Jan. 1, 1998, see section 1531(c) of Pub. L. 105–34, set out as a note under section 4980D of this title.

EFFECTIVE DATE

Section applicable to plan years beginning after June 30, 1997, see section 401(c) of Pub. L. 104–191, set out as a note under section 9801 of this title.

§ 9832. Definitions

(a) Group health plan

For purposes of this chapter, the term ''group health plan'' has the meaning given to such term by section 5000(b)(1).

(b) Definitions relating to health insurance

For purposes of this chapter—

(1) Health insurance coverage

(A) In general

Except as provided in subparagraph (B), the term ''health insurance coverage'' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(B) No application to certain excepted benefits

In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

(2) Health insurance issuer

The term ''health insurance issuer'' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

(3) Health maintenance organization

The term ''health maintenance organization'' means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),