

erage, 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 or beneficiary 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 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 or beneficiary 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.

(Pub. L. 93-406, title I, §722, as added Pub. L. 116-260, div. BB, title I, §102(b)(2), Dec. 27, 2020, 134 Stat. 2783.)

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section 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 an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

§ 1185l. Air ambulance report requirements

(a) In general

Each group health plan and health insurance issuer offering group health insurance coverage shall submit to the Secretary, jointly with the

Secretary of Health and Human Services and the Secretary of the Treasury—

(1) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rule-making described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

(2) not later than the date that is 90 days after the last day of the plan year immediately succeeding the calendar year described in paragraph (1), such information with respect to such immediately succeeding plan year.

(b) Information described

For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group health insurance coverage, is each of the following:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored program, 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.

(Pub. L. 93-406, title I, §723, as added Pub. L. 116-260, div. BB, title I, §106(b)(2)(A), Dec. 27, 2020, 134 Stat. 2853.)

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.

§ 1185m. 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 (or an issuer of health insurance coverage offered in connection with such a plan) may not enter into an agreement with a health care provider, network or asso-

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

ciation 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 or health insurance issuer offering such coverage 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 or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan or coverage, 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 [42 U.S.C. 12101 et seq.], 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 [42 U.S.C. 12101 et seq.].

(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 (or health insurance coverage offered in connection with such a plan) shall annually submit to the Secretary an attestation that such plan or issuer of such coverage 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, plan sponsor, or health insurance

issuer 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 [42 U.S.C. 12101 et seq.].

(Pub. L. 93-406, title I, §724, as added Pub. L. 116-260, div. BB, title II, §201(b), Dec. 27, 2020, 134 Stat. 2892.)

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.

§ 1185n. Reporting on pharmacy benefits and drug costs

(a) In general

Not later than 1 year after December 27, 2020, and not later than June 1 of each year thereafter, a group health plan (or health insurance coverage offered in connection with such a plan) shall submit to the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury the following information with respect to the health plan or coverage 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 or coverage is offered.
- (4) The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.
- (5) The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage 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 or coverage in each such plan year.
- (7) Total spending on health care services by such group health plan or health insurance coverage, 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;