

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;

(iii) costs for prescription drugs; and
 (iv) other medical costs, including wellness services; and

(B) spending on prescription drugs by—
 (i) the health plan or coverage; 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 coverage or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan or coverage, 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 or coverage 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 Labor, shall make available on the internet website of the Department of Labor a report on prescription drug reimbursements under group health plans (or health insurance coverage offered in connection with such a plan), prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage, 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).

(Pub. L. 93-406, title I, §725, as added Pub. L. 116-260, div. BB, title II, §204(b), Dec. 27, 2020, 134 Stat. 2919.)

Subpart C—General Provisions

§ 1191. Preemption; State flexibility; construction

(a) Continued applicability of State law with respect to health insurance issuers

(1) In general

Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) Continued preemption with respect to group health plans

Nothing in this part shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.

(b) Special rules in case of portability requirements

(1) In general

Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 1181 of this title which differs from the standards or requirements specified in such section.

(2) Exceptions

Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(A) substitutes for the reference to “6-month period” in section 1181(a)(1) of this title a reference to any shorter period of time;

(B) substitutes for the reference to “12 months” and “18 months” in section 1181(a)(2) of this title a reference to any shorter period of time;

(C) substitutes for the references to “63 days” in sections 1181(c)(2)(A) and (d)(4)(A)¹ of this title a reference to any greater number of days;

(D) substitutes for the reference to “30-day period” in sections 1181(b)(2)² and (d)(1) of this title a reference to any greater period;

(E) prohibits the imposition of any preexisting condition exclusion in cases not described in section 1181(d) of this title or expands the exceptions described in such section;

(F) requires special enrollment periods in addition to those required under section 1181(f) of this title; or

(G) reduces the maximum period permitted in an affiliation period under section 1181(g)(1)(B)³ of this title.

(c) Rules of construction

Except as provided in section 1185 of this title, nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(d) Definitions

For purposes of this section—

(1) State law

The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A

¹ So in original. Section 1181(d)(4) of this title does not contain subpars.

² So in original. Section 1181(b)(2) of this title does not refer to a 30-day period.

³ So in original. Probably should be “1181(g)(1)(C)”.