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.].

(3) Clarification regarding public disclosure of information

Nothing in paragraph (1)(A) or (2)(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 paragraphs (1) and (2).

(4) Attestation

A group health plan or a health insurance issuer offering group or individual health insurance coverage 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.

(5) 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.].

(July 1, 1944, ch. 373, title XXVII, §2799A–9, as added Pub. L. 116–260, div. BB, title II, §201(a), Dec. 27, 2020, 134 Stat. 2890.)

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), (2)(B), (5), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

The Genetic Information Nondiscrimination Act of 2008, referred to in subsec. (a)(1)(B), (C), (2)(B), (5), 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 this title and Tables.

The Americans with Disabilities Act of 1990, referred to in subsec. (a)(1)(B), (C), (2)(B), (5), is Pub. L. 101–336, July 26, 1990, 104 Stat. 327, which is classified principally to chapter 126 (§12101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 12101 of this title and Tables.

§ 300gg–120. 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 issuer offering group or individual health insurance coverage (except for a church plan) shall submit to the Secretary, the Secretary of Labor, 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 enrollees.

(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 enrollees.

(8) The average monthly premium—

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

(B) paid by enrollees.

(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 enrollees 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 through the Assistant Secretary of Planning and Evaluation and in coordination with the Inspector General of the Department of Health and Human Services, shall make available on the internet website of the Department of Health and Human Services a report on prescription drug reimbursements under group health plans and group and individual health insurance coverage, 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).

(July 1, 1944, ch. 373, title XXVII, § 2799A–10, as added Pub. L. 116–260, div. BB, title II, § 204(a), Dec. 27, 2020, 134 Stat. 2918.)

PART E—HEALTH CARE PROVIDER REQUIREMENTS

Statutory Notes and Related Subsidiaries

DEFINITIONS

For additional definitions applicable to this part, see section 300gg–111(a)(3) of this title.

§ 300gg–131. Balance billing in cases of emergency services

(a) In general

In the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, emergency services (for which benefits are provided under the plan or coverage) with respect to an emergency medical condition with respect to a visit at an emergency department of a hospital or an independent freestanding emergency department—

(1) in the case that the hospital or independent freestanding emergency department is a nonparticipating emergency facility, the emergency department of a hospital or independent freestanding emergency department shall not bill, and shall not hold liable, the participant, beneficiary, or enrollee for a payment amount for such emergency services so furnished that is more than the cost-sharing requirement for such services (as determined in accordance with clauses (ii) and (iii) of section 300gg–111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable); and

(2) in the case that such services are furnished by a nonparticipating provider, the health care provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for an emergency service furnished to such individual by such provider with respect to such emergency medical condition and visit for which the individual receives emergency services at the hospital or emergency department that is more than the cost-sharing requirement for such services furnished by the provider (as determined in accordance with clauses (ii) and (iii) of section 300gg–111(a)(1)(C) of this title, of section 9816(a)(1)(C) of title 26, and of section 1185e(a)(1)(C) of title 29, as applicable).

(b) Definition

In this section, the term ''visit'' shall have such meaning as applied to such term for purposes of section 300gg–111(b) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2799B–1, as added Pub. L. 116–260, div. BB, title I, § 104(a), Dec. 27, 2020, 134 Stat. 2824.)

§ 300gg–132. Balance billing in cases of non-emergency services performed by nonparticipating providers at certain participating facilities

(a) In general

Subject to subsection (b), in the case of a participant, beneficiary, or enrollee with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer and who is furnished during a plan year beginning on or after January 1, 2022, items or services (other than emergency services to which section 300gg–131 of this title applies) for which benefits are provided under the plan or coverage at a participating health care facility by a nonparticipating provider, such provider shall not bill, and shall not hold liable, such participant, beneficiary, or enrollee for a payment amount for such an item or service furnished by such provider with respect to a visit at such facility that is more than the cost-sharing requirement for such item or service (as determined in accordance with subparagraphs (A) and (B) of section 300gg–111(b)(1) of this title[1] of section 9816(b)(1) of title 26, and of section 1185e(b)(1) of title 29, as applicable).

(b) Exception

(1) In general

Subsection (a) shall not apply with respect to items or services (other than ancillary services described in paragraph (2)) furnished by a nonparticipating provider to a participant, beneficiary, or enrollee of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, if the provider satisfies the notice and consent criteria of subsection (d).

(2) Ancillary services described

For purposes of paragraph (1), ancillary services described in this paragraph are, with respect to a participating health care facility—

(A) subject to paragraph (3), items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;

(B) subject to paragraph (3), diagnostic services (including radiology and laboratory services);

(C) items and services provided by such other specialty practitioners, as the Secretary specifies through rulemaking; and

(D) items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(3) Exception

The Secretary may, through rulemaking, establish a list (and update such list periodically) of advanced diagnostic laboratory tests,

[1] So in original. Probably should be followed by a comma.