necessary and appropriate by the Secretary of Health and Human Services and Secretary of Transportation.

''(3) FIRST MEETING.—Not later than the date that is 90 days after the date of the enactment of this Act, the Committee shall hold its first meeting.

''(4) DUTIES.—The Committee shall study and make recommendations, as appropriate, to Congress regarding each of the following with respect to air ambulance services:

''(A) Qualifications of different clinical capability levels and tiering of such levels.

''(B) Patient safety and quality standards.

''(C) Options for improving service reliability during poor weather, night conditions, or other adverse conditions.

''(D) Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

''(E) Clinical triage criteria for air ambulances.

''(5) REPORT.—Not later than the date that is 180 days after the date of the first meeting of the Committee, the Committee, in consultation with relevant experts and stakeholders, as appropriate, shall develop and make publicly available a report on any recommendations submitted to Congress under paragraph (4). The Committee may update such report, as determined appropriate by the Committee.

''(h) DEFINITIONS.—In this section, the terms 'group health plan', 'health insurance coverage', 'individual health insurance coverage', 'group health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).''

§ 300gg–119. Increasing transparency by removing gag clauses on price and quality information

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

(1) Group health plans

A group health plan or health insurance issuer offering group health insurance coverage 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 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, enrollees, or individuals eligible to become enrollees of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each enrollee 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) Individual health insurance coverage

A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (A) 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.].

(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 con-

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

strued 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