117TH CONGRESS
2D SESSION

S. 5093

To further protect patients and improve the accuracy of provider directory information by eliminating ghost networks.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 15, 2022

Ms. SMITH (for herself and Mr. WYDEN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To further protect patients and improve the accuracy of provider directory information by eliminating ghost networks.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Behavioral Health Network and Directory Improvement Act''.

SEC. 2. PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

(a) PHSA.—Section 2799A–5 of the Public Health Service Act (42 U.S.C. 300gg–115) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''For plan years beginning on or after January 1, 2022, each'' and inserting ''Each'';

(ii) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(iii) in subparagraph (D), by striking the period and inserting ''; and''; and

(iv) by adding at the end the following:

''(E) ensure that any directory, including the database described in subparagraph (C), containing provider directory information with respect to such plan or such coverage complies with the requirements developed by the appropriate agencies in accordance with paragraph (6) in order to ensure that participants, beneficiaries, and enrollees are able to identify actively participating health care providers and health care facilities.'';

(B) in paragraph (2)(A), by striking ''90 days'' and inserting ''30 days'';

(C) in paragraph (3)—

(i) in the matter preceding subparagraph (A), by striking ‘‘, in the case such request is made through a telephone call’’; and

(ii) in subparagraph (A), by striking ‘‘call is received, through a written electronic or print (as requested by such individual) communication’’ and inserting ‘‘a request is received, by telephone, or through a written electronic or print communication (as requested by such individual)’’;

(D) in paragraph (4)—

(i) in subparagraph (A), by striking ‘‘and’’ at the end;

(ii) in subparagraph (B), by striking the period and inserting ‘‘; and’’; and

(iii) by adding at the end the following:

‘‘(C) information, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reliance on inaccurate provider network information supplied by a group health plan or health

insurance issuer, and contact information for the State consumer assistance program or ombudsman for more information.'';

(E) in paragraph (5), by adding at the end the following: ''Such information shall include a statement, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reliance on inaccurate provider directory information supplied by a group health plan or health insurance issuer, and contact information for the State consumer assistance program or ombudsman for more information.'';

(F) by redesignating paragraphs (6) and (7) as paragraphs (8) and (9), respectively;

(G) by inserting after paragraph (5) the following:

''(6) PROTECTING PARTICIPANTS, BENEFICIARIES, AND ENROLLEES FROM GHOST NETWORKS.—The Secretary, in collaboration with the Secretary of Labor and the Secretary of the Treasury, shall—

''(A) not later than 180 days after the date of enactment of the Behavioral Health Network

and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) further defining the term 'ghost network' (as defined in paragraph (8)); and

''(B) not later than 18 months after the date of enactment of the Behavioral Health Network and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code), subregulatory guidance, or program instruction on how to assess ghost networks in health plan directories including reasonable assumptions related to statistics and research methods.

''(7) DATABASE REPORTING AND AUDITING TO PROTECT AGAINST GHOST NETWORKS.—

''(A) REPORTING REQUIREMENTS.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, at such time as the

Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall require, but not less frequently than annually, the directory data described in paragraph (a)(4), in a machine readable format (as defined in section 147.210(a)(2)(xiv) of title 45, Code of Federal Regulations (or any successor regulations)). The Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall make data submitted under this subparagraph available on a public website.

''(B) PROVIDER DIRECTORY INDEPENDENT AUDIT REQUIREMENTS.—

''(i) IN GENERAL.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, each group health plan and health insurance issuer offering group or individual health insurance coverage shall conduct an annual directory audit, through an independent entity not associated with the health plan or issuer, that considers the factors described in clause (ii)(I)(aa) and follows the

guidelines developed under clause (ii)(I)(bb).

"(ii) FACTORS.—

"(I) IN GENERAL.—For purposes of carrying out the audits under this subparagraph, the Secretary shall—

"(aa) develop a list of factors to be considered; and

"(bb) provide guidelines for carrying out such audits, for use by group health plans and health insurance issuers, on—

"(AA) the reasonable assumptions and research methods to select a reasonable sample in order to assess provider directory information accuracy; and

"(BB) determining the criteria of an eligible auditor.

"(II) CONTENTS.—The factors under subclause (I)(aa) shall include the following:

"(aa) A list of every health care provider and health care facility that was part of the network of the applicable plan or coverage, the months during the plan year during which each such provider or facility was part of the network, and the number of participants, beneficiaries, and enrollees in the plan or coverage (including participants, beneficiaries, and enrollees who are new patients of the provider) each such provider or facility treated during such period.

"(bb) The proportion of directory listings of the plan or coverage with inaccurate information, including incorrect contact information, including incorrect contact information, as specified by the Secretary, during the audit period.

"(cc) The number of in-network items or services paid on

behalf of participants, beneficiaries, and enrollees in the plan or coverage to providers or facilities who have a network provider contract with the health plan or issuer and were not listed in the directory of the health plan or health insurance coverage for the audit period.

''(dd) The resources of the plan or issuer to help participants, beneficiaries, and enrollees locate an accurately listed in-network provider who is accepting new patients.

''(ee) The proportion of participants, beneficiaries, and enrollees using out-of-network providers for mental health and substance use disorder services, and the proportion of participants, beneficiaries, and enrollees using out-of-network providers and facilities for medical and surgical services.

"(ff) Documentation that the plan or issuer verifies the accuracy of the provider directory information every 30 days.

"(gg) Other factors as determined by the Secretary.

"(iii) REQUIREMENTS OF THE INDEPENDENT AUDIT.—An audit under this subparagraph is complete if all of the following conditions are met:

"(I) The audit report includes the following:

"(aa) A statement by the independent auditor that, to the best of the auditor's knowledge, the report is complete and accurate, and that reasonable assumptions related to statistics and research methods have been complied with.

"(bb) A statement explaining the assumptions, statistics, and methods used to select the sample and assess provider directory information accuracy.

''(cc) Such other information as the Secretary determines necessary.

''(II) The group health plan or health insurer issuer makes the independent audit available on a public website.

''(iv) RULEMAKING.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) concerning the national standards for conducting audits under this subparagraph, not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act.

''(C) AUDITS BY THE SECRETARY.—

''(i) IN GENERAL.—Beginning not later than the third plan year after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary shall conduct annual audits to ensure compliance with the

provider directory requirements of this subsection.

''(ii) REQUIREMENTS.—Audits conducted by the Secretary under this subparagraph shall—

''(I) assess the accuracy of the information provided in health plan directories required under this subsection, including the proportion of listings with incorrect information, the last date on which the behavioral health network of the group health plan or health insurance coverage was updated, and other information determined appropriate by the Secretary; and

''(II) use reasonable assumptions related to statistics and research methods to identify a representative sample of listings for analysis and such methods as the Secretary determines appropriate, which may include retrospective analysis of billing data.

''(iii) SELECTION OF PLANS AND ISSUERS.—The Secretary shall conduct an-

nual audits of a total of not fewer than 10 group health plans or health insurance issuers offering group or individual health insurance coverage, as determined by the Secretary, that are the subjects of complaints about ghost networks or other complaints, or that are randomly selected by the Secretary.''; and

(H) in paragraph (8), as so redesignated—

(i) in the paragraph heading, by striking ''DEFINITION'' and inserting ''DEFINITIONS'';

(ii) by striking ''For purposes of this subsection, the term'' and inserting the following: ''For purposes of this subsection:

''(A) PROVIDER DIRECTORY INFORMATION.—The term'';

(iii) by striking ''health insurance coverage, the name'' and inserting ''health insurance coverage—

''(i) the name'';

(iv) by striking the period and inserting ''; and''; and

(v) by adding at the end the following:

"(ii) with respect to each such provider or facility—

"(I) whether such provider or facility is accepting new patients;

"(II) the languages spoken and the availability of language translators for specified languages at each health care facility listed in the directory;

"(III) whether the provider or facility offers medication-assisted treatment for opioid use disorder;

"(IV) the State license number;

"(V) the national provider identifier;

"(VI) the age groups served by the provider or facility, such as pediatric, adolescent, adult, or geriatric populations;

"(VII) whether such provider or facility offers in-person services, telehealth services, or both; and

"(VIII) the cost-sharing tier, if applicable.

"(B) GHOST NETWORK.—The term 'ghost network' means a group health plan or group or

individual health insurance coverage for which the provider directory information describing the network of such plan or coverage—

"(i) does not include accurate required information for purposes of making an appointment for in-network care within a reasonable time period;

"(ii) includes a meaningful number of providers and facilities (as specified by the Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury) in a specialty who are not accepting new patients within a time period specified by such secretaries;

"(iii) includes providers that are not part of the network; or

"(iv) omits providers that are part of the network."; and

(2) in subsection (b)—

(A) in paragraph (1), by striking "and if either of the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service"; and

(B) by striking paragraph (2) and inserting the following:

''(2) RECONCILIATION REQUIREMENT.—For purposes of paragraph (1), a group health plan or group or individual health insurance coverage offered by a health insurance issuer, on a regular basis, shall reconcile payment requests for items or services furnished by a nonparticipating provider or a nonparticipating facility and the posted provider directory database for the day the delivered item or service was provided. If a nonparticipating provider was listed as a participating provider in the directory, the group health plan or health insurance issuer shall notify the participant, beneficiary, or enrollee, in plain language, that the participant, beneficiary, or enrollee may be eligible for a refund from the group health plan or health insurance issuer if such participant, beneficiary, or enrollee paid the out of network cost-sharing and did not receive a refund under section 2799B–9(b).''.

(b) ERISA.—

(1) IN GENERAL.—Section 720 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185i) is amended—

(A) in subsection (a)—

(i) in paragraph (1)—

(I) by striking ''For plan years beginning on or after January 1, 2022, each'' and inserting ''Each'';

(II) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(III) in subparagraph (D), by striking the period and inserting ''; and''; and

(IV) by adding at the end the following:

''(E) ensure that any directory, including the database described in subparagraph (C), containing provider directory information with respect to such plan or such coverage complies with the requirements developed by the appropriate agencies in accordance with paragraph (6) in order to ensure that participants, beneficiaries, and enrollees are able to identify actively participating health care providers and health care facilities.'';

(ii) in paragraph (2)(A), by striking ''90 days'' and inserting ''30 days'';

(iii) in paragraph (3)—

(I) in the matter preceding subparagraph (A), by striking ‘‘, in the case such request is made through a telephone call’’; and

(II) in subparagraph (A), by striking ‘‘call is received, through a written electronic or print (as requested by such individual) communication’’ and inserting ‘‘a request is received, by telephone, or through a written electronic or print communication (as requested by such individual)’’;

(iv) in paragraph (4)—

(I) in subparagraph (A), by striking ‘‘and’’ at the end;

(II) in subparagraph (B), by striking the period and inserting ‘‘; and’’; and

(III) by adding at the end the following:

‘‘(C) information, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reli-

ance on inaccurate provider network information supplied by a group health plan or health insurance issuer, and contact information for the State consumer assistance program or ombudsman for more information.'';

(v) in paragraph (5), by adding at the end the following: ''Such information shall include a statement, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reliance on inaccurate provider directory information supplied by a group health plan or health insurance issuer, and contact information for the State consumer assistance program or ombudsman for more information.'';

(vi) by redesignating paragraphs (6) and (7) as paragraphs (8) and (9), respectively;

(vii) by inserting after paragraph (5) the following:

''(6) PROTECTING PARTICIPANTS, BENEFICIARIES, AND ENROLLEES FROM GHOST NETWORKS.—The Secretary, in collaboration with the

Secretary of Labor and the Secretary of the Treasury, shall—

"(A) not later than 180 days after the date of enactment of the Behavioral Health Network and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) further defining the term 'ghost network' (as defined in paragraph (8)); and

"(B) not later than 18 months after the date of enactment of the Behavioral Health Network and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code), subregulatory guidance, or program instruction on how to assess ghost networks in health plan directories including reasonable assumptions related to statistics and research methods.

"(7) DATABASE REPORTING AND AUDITING TO PROTECT AGAINST GHOST NETWORKS.—

"(A) REPORTING REQUIREMENTS.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network and

Directory Improvement Act, each group health plan and health insurance issuer offering group health insurance coverage shall submit to the Secretary, at such time as the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, shall require, but not less frequently than annually, the directory data described in paragraph (a)(4), in a machine readable format (as defined in section 147.210(a)(2)(xiv) of title 45, Code of Federal Regulations (or any successor regulations)). The Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, shall make data submitted under this subparagraph available on a public website.

''(B) PROVIDER DIRECTORY INDEPENDENT AUDIT REQUIREMENTS.—

''(i) IN GENERAL.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, each group health plan and health insurance issuer offering group health insurance coverage shall conduct an annual directory

audit, through an independent entity not associated with the health plan or issuer, that considers the factors described in clause (ii)(I)(aa) and follows the guidelines developed under clause (ii)(I)(bb).

"(ii) FACTORS.—

"(I) IN GENERAL.—For purposes of carrying out the audits under this subparagraph, the Secretary shall—

"(aa) develop a list of factors to be considered; and

"(bb) provide guidelines for carrying out such audits, for use by group health plans and health insurance issuers, on—

"(AA) the reasonable assumptions and research methods to select a reasonable sample in order to assess provider directory information accuracy; and

"(BB) determining the criteria of an eligible auditor.

"(II) CONTENTS.—The factors under subclause (I)(aa) shall include the following:

"(aa) A list of every health care provider and health care facility that was part of the network of the applicable plan or coverage, the months during the plan year during which each such provider or facility was part of the network, and the number of participants, beneficiaries, and enrollees in the plan or coverage (including participants, beneficiaries, and enrollees who are new patients of the provider) each such provider or facility treated during such period.

"(bb) The proportion of directory listings of the plan or coverage with inaccurate information, including incorrect contact information, including incorrect contact information, as spec-

ified by the Secretary, during the audit period.

''(cc) The number of in-network items or services paid on behalf of participants, beneficiaries, and enrollees in the plan or coverage to providers or facilities who have a network provider contract with the health plan or issuer and were not listed in the directory of the health plan or health insurance coverage for the audit period.

''(dd) The resources of the plan or issuer to help participants, beneficiaries, and enrollees locate an accurately listed in-network provider who is accepting new patients.

''(ee) The proportion of participants, beneficiaries, and enrollees using out-of-network providers for mental health and substance use disorder services, and the proportion of participants,

beneficiaries, and enrollees using out-of-network providers and facilities for medical and surgical services.

"(ff) Documentation that the plan or issuer verifies the accuracy of the provider directory information every 30 days.

"(gg) Other factors as determined by the Secretary.

"(iii) REQUIREMENTS OF THE INDEPENDENT AUDIT.—An audit under this subparagraph is complete if all of the following conditions are met:

"(I) The audit report includes the following:

"(aa) A statement by the independent auditor that, to the best of the auditor's knowledge, the report is complete and accurate, and that reasonable assumptions related to statistics and research methods have been complied with.

''(bb) A statement explaining the assumptions, statistics, and methods used to select the sample and assess provider directory information accuracy.

''(cc) Such other information as the Secretary determines necessary.

''(II) The group health plan or health insurer issuer makes the independent audit available on a public website.

''(iv) RULEMAKING.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) concerning the national standards for conducting audits under this subparagraph, not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act.

''(C) AUDITS BY THE SECRETARY.—

''(i) IN GENERAL.—Beginning not later than the third plan year after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary shall conduct annual audits to ensure compliance with the provider directory requirements of this subsection.

''(ii) REQUIREMENTS.—Audits conducted by the Secretary under this subparagraph shall—

''(I) assess the accuracy of the information provided in health plan directories required under this subsection, including the proportion of listings with incorrect information, the last date on which the behavioral health network of the group health plan or health insurance coverage was updated, and other information determined appropriate by the Secretary; and

''(II) use reasonable assumptions related to statistics and research methods to identify a representative

sample of listings for analysis and such methods as the Secretary determines appropriate, which may include retrospective analysis of billing data.

''(iii) SELECTION OF PLANS AND ISSUERS.—The Secretary shall conduct annual audits of a total of not fewer than 10 group health plans or health insurance issuers offering group health insurance coverage, as determined by the Secretary, that are the subjects of complaints about ghost networks or other complaints, or that are randomly selected by the Secretary.''; and

(viii) in paragraph (8), as so redesignated—

(I) in the paragraph heading, by striking ''DEFINITION'' and inserting ''DEFINITIONS'';

(II) by striking ''For purposes of this subsection, the term'' and inserting the following: ''For purposes of this subsection:

''(A) PROVIDER DIRECTORY INFORMATION.—The term'';

(III) by striking ''health insurance coverage, the name'' and inserting ''health insurance coverage—

''(i) the name'';

(IV) by striking the period and inserting ''; and''; and

(V) by adding at the end the following:

''(ii) with respect to each such provider or facility—

''(I) whether such provider or facility is accepting new patients;

''(II) the languages spoken and the availability of language translators for specified languages at each health care facility listed in the directory;

''(III) whether the provider or facility offers medication-assisted treatment for opioid use disorder;

''(IV) the State license number;

''(V) the national provider identifier;

''(VI) the age groups served by the provider or facility, such as pedi-

atric, adolescent, adult, or geriatric populations;

"(VII) whether such provider or facility offers in-person services, telehealth services, or both; and

"(VIII) the cost-sharing tier, if applicable.

"(B) GHOST NETWORK.—The term 'ghost network' means a group health plan or group health insurance coverage for which the provider directory information describing the network of such plan or coverage—

"(i) does not include accurate required information for purposes of making an appointment for in-network care within a reasonable time period;

"(ii) includes a meaningful number of providers and facilities (as specified by the Secretary, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury) in a specialty who are not accepting new patients within a time period specified by such secretaries;

''(iii) includes providers that are not part of the network; or

''(iv) omits providers that are part of the network.''; and

(B) in subsection (b)—

(i) in paragraph (1), by striking ''and if either of the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service''; and

(ii) by striking paragraph (2) and inserting the following:

''(2) RECONCILIATION REQUIREMENT.—For purposes of paragraph (1), a group health plan or group health insurance coverage offered by a health insurance issuer, on a regular basis, shall reconcile payment requests for items or services furnished by a nonparticipating provider or a nonparticipating facility and the posted provider directory database for the day the delivered item or service was provided. If a nonparticipating provider was listed as a participating provider in the directory, the group health plan or health insurance issuer shall notify the participant, beneficiary, or enrollee, in plain language, that the participant, beneficiary, or enrollee may be

eligible for a refund from the group health plan or health insurance issuer if such participant, beneficiary, or enrollee paid the out of network cost-sharing and did not receive a refund under section 2799B–9(b) of the Public Health Service Act (42 U.S.C. 300gg–139).''.

(2) CIVIL MONETARY PENALTIES FOR VIOLATIONS.—

(A) CIVIL MONETARY PENALTIES RELATING TO PROVIDER DIRECTORY REQUIREMENTS.—Section 502(c)(10) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)(10)(A)) is amended—

(i) in the heading, by striking ''USE OF GENETIC INFORMATION'' and inserting ''USE OF GENETIC INFORMATION AND PROVIDER DIRECTORY REQUIREMENTS''; and

(ii) in subparagraph (A)—

(I) by striking ''any plan sponsor of a group health plan'' and inserting ''any plan sponsor or plan administrator of a group health plan''; and

(II) by striking ''for any failure'' and all that follows through ''in connection with the plan.'' and inserting

''for any failure by such plan sponsor, plan administrator, or health insurance issuer, in connection with the plan—

''(i) to meet the requirements of subsection (a)(1)(F), (b)(3), (c), or (d) of section 702 or section 701 or 702(b)(1) with respect to genetic information; or

''(ii) to meet the requirements of section 720 with respect to provider directory information.''.

(B) EXCEPTION TO THE GENERAL PROHIBITION ON ENFORCEMENT.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking ''or (9)'' and inserting ''(9), or (10)''; and

(ii) in subsection (b)(3)—

(I) by striking ''subsections (c)(9) and (a)(6)'' and inserting ''subsections (c)(9), (c)(10), and (a)(6)'';

(II) by striking ''under subsection (c)(9))'' and inserting ''under subsections (c)(9) and (c)(10)), and except with respect to enforcement by the Secretary of section 720''; and

(III) by striking ''706(a)(1)'' and inserting ''733(a)(1)''.

(C) EFFECTIVE DATE.—The amendments made by subparagraph (A) shall apply with respect to group health plans, or any health insurance issuer offering health insurance coverage in connection with such plan, for plan years beginning after the date that is 1 year after the date of enactment of this Act.

(c) IRC.—Section 9820 of the Internal Revenue Code of 1986 is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''For plan years beginning on or after January 1, 2022, each'' and inserting ''Each'';

(ii) in subparagraph (C), by striking ''; and'' and inserting a semicolon;

(iii) in subparagraph (D), by striking the period and inserting ''; and''; and

(iv) by adding at the end the following:

''(E) ensure that any directory, including the database described in subparagraph (C), containing provider directory information with

respect to such plan complies with the requirements developed by the appropriate agencies in accordance with paragraph (6) in order to ensure that participants, beneficiaries, and enrollees are able to identify actively participating health care providers and health care facilities.'';

(B) in paragraph (2)(A), by striking ''90 days'' and inserting ''30 days'';

(C) in paragraph (3)—

(i) in the matter preceding subparagraph (A), by striking '', in the case such request is made through a telephone call''; and

(ii) in subparagraph (A), by striking ''call is received, through a written electronic or print (as requested by such individual) communication'' and inserting ''a request is received, by telephone, or through a written electronic or print communication (as requested by such individual)'';

(D) in paragraph (4)—

(i) in subparagraph (A), by striking ''and'' at the end;

(ii) in subparagraph (B), by striking the period and inserting ''; and''; and

(iii) by adding at the end the following:

''(C) information, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reliance on inaccurate provider network information supplied by a group health plan, and contact information for the State consumer assistance program or ombudsman for more information.'';

(E) in paragraph (5), by adding at the end the following: ''Such information shall include a statement, in plain language, concerning the rights of the participant, beneficiary, or enrollee to cost-sharing protections pursuant to subsection (b) in the event of reliance on inaccurate provider directory information supplied by a group health plan, and contact information for the State consumer assistance program or ombudsman for more information.'';

(F) by redesignating paragraphs (6) and (7) as paragraphs (8) and (9), respectively;

(G) by inserting after paragraph (5) the following:

''(6) PROTECTING PARTICIPANTS, BENEFICIARIES, AND ENROLLEES FROM GHOST NETWORKS.—The Secretary, in collaboration with the Secretary of Labor and the Secretary of Health and Human Services, shall—

''(A) not later than 180 days after the date of enactment of the Behavioral Health Network and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) further defining the term 'ghost network' (as defined in paragraph (8)); and

''(B) not later than 18 months after the date of enactment of the Behavioral Health Network and Directory Improvement Act, issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code), subregulatory guidance, or program instruction on how to assess ghost networks in health plan directories including reasonable assumptions related to statistics and research methods.

"(7) DATABASE REPORTING AND AUDITING TO PROTECT AGAINST GHOST NETWORKS.—

"(A) REPORTING REQUIREMENTS.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, each group health plan shall submit to the Secretary, at such time as the Secretary, in coordination with the Secretary of Labor and the Secretary of Health and Human Services, shall require, but not less frequently than annually, the directory data described in paragraph (a)(4), in a machine readable format (as defined in section 147.210(a)(2)(xiv) of title 45, Code of Federal Regulations (or any successor regulations)). The Secretary, in coordination with the Secretary of Labor and the Secretary of Health and Human Services, shall make data submitted under this subparagraph available on a public website.

"(B) PROVIDER DIRECTORY INDEPENDENT AUDIT REQUIREMENTS.—

"(i) IN GENERAL.—Beginning not later than 3 years after the date of enactment of the Behavioral Health Network

and Directory Improvement Act, each group health plan shall conduct an annual directory audit, through an independent entity not associated with the health plan, that considers the factors described in clause (ii)(I)(aa) and follows the guidelines developed under clause (ii)(I)(bb).

''(ii) FACTORS.—

''(I) IN GENERAL.—For purposes of carrying out the audits under this subparagraph, the Secretary shall—

''(aa) develop a list of factors to be considered; and

''(bb) provide guidelines for carrying out such audits, for use by group health plans, on—

''(AA) the reasonable assumptions and research methods to select a reasonable sample in order to assess provider directory information accuracy; and

''(BB) determining the criteria of an eligible auditor.

"(II) CONTENTS.—The factors under subclause (I)(aa) shall include the following:

"(aa) A list of every health care provider and health care facility that was part of the network of the applicable plan, the months during the plan year during which each such provider or facility was part of the network, and the number of participants, beneficiaries, and enrollees in the plan (including participants, beneficiaries, and enrollees who are new patients of the provider) each such provider or facility treated during such period.

"(bb) The proportion of directory listings of the plan with inaccurate information, including incorrect contact information, including incorrect contact information, as specified by the Secretary, during the audit period.

"(cc) The number of in-network items or services paid on behalf of participants, beneficiaries, and enrollees in the plan to providers or facilities who have a network provider contract with the health plan and were not listed in the directory of the health plan for the audit period.

"(dd) The resources of the plan to help participants, beneficiaries, and enrollees locate an accurately listed in-network provider who is accepting new patients.

"(ee) The proportion of participants, beneficiaries, and enrollees using out-of-network providers for mental health and substance use disorder services, and the proportion of participants, beneficiaries, and enrollees using out-of-network providers and facilities for medical and surgical services.

"(ff) Documentation that the plan verifies the accuracy of the provider directory information every 30 days.

"(gg) Other factors as determined by the Secretary.

"(iii) REQUIREMENTS OF THE INDEPENDENT AUDIT.—An audit under this subparagraph is complete if all of the following conditions are met:

"(I) The audit report includes the following:

"(aa) A statement by the independent auditor that, to the best of the auditor's knowledge, the report is complete and accurate, and that reasonable assumptions related to statistics and research methods have been complied with.

"(bb) A statement explaining the assumptions, statistics, and methods used to select the sample and assess provider directory information accuracy.

"(cc) Such other information as the Secretary determines necessary.

"(II) The group health plan makes the independent audit available on a public website.

"(iv) RULEMAKING.—The Secretary, the Secretary of Labor, and the Secretary of Health and Human Services shall issue interim final regulations (without prior notice and comment as required under section 553 of title 5, United States Code) concerning the national standards for conducting audits under this subparagraph, not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act.

"(C) AUDITS BY THE SECRETARY.—

"(i) IN GENERAL.—Beginning not later than the third plan year after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary shall conduct annual audits to ensure compliance with the

provider directory requirements of this subsection.

''(ii) REQUIREMENTS.—Audits conducted by the Secretary under this subparagraph shall—

''(I) assess the accuracy of the information provided in health plan directories required under this subsection, including the proportion of listings with incorrect information, the last date on which the behavioral health network of the group health plan was updated, and other information determined appropriate by the Secretary; and

''(II) use reasonable assumptions related to statistics and research methods to identify a representative sample of listings for analysis and such methods as the Secretary determines appropriate, which may include retrospective analysis of billing data.

''(iii) SELECTION OF PLANS.—The Secretary shall conduct annual audits of a total of not fewer than 10 group health

plans, as determined by the Secretary, that are the subjects of complaints about ghost networks or other complaints, or that are randomly selected by the Secretary.''; and

(H) in paragraph (8), as so redesignated—

(i) in the paragraph heading, by striking ''DEFINITION'' and inserting ''DEFINITIONS'';

(ii) by striking ''For purposes of this subsection, the term'' and inserting the following: ''For purposes of this subsection:

''(A) PROVIDER DIRECTORY INFORMATION.—The term'';

(iii) by striking ''group health plan, the name'' and inserting ''group health plan—

''(i) the name'';

(iv) by striking the period and inserting ''; and''; and

(v) by adding at the end the following:

''(ii) with respect to each such provider or facility—

''(I) whether such provider or facility is accepting new patients;

"(II) the languages spoken and the availability of language translators for specified languages at each health care facility listed in the directory;

"(III) whether the provider or facility offers medication-assisted treatment for opioid use disorder;

"(IV) the State license number;

"(V) the national provider identifier;

"(VI) the age groups served by the provider or facility, such as pediatric, adolescent, adult, or geriatric populations;

"(VII) whether such provider or facility offers in-person services, telehealth services, or both; and

"(VIII) the cost-sharing tier, if applicable.

"(B) GHOST NETWORK.—The term 'ghost network' means a group health plan for which the provider directory information describing the network of such plan—

"(i) does not include accurate required information for purposes of making

an appointment for in-network care within a reasonable time period;

''(ii) includes a meaningful number of providers and facilities (as specified by the Secretary, in coordination with the Secretary of Labor and the Secretary of Health and Human Services) in a specialty who are not accepting new patients within a time period specified by such secretaries;

''(iii) includes providers that are not part of the network; or

''(iv) omits providers that are part of the network.''; and

(2) in subsection (b)—

(A) in paragraph (1), by striking ''and if either of the criteria described in paragraph (2) applies with respect to such participant, beneficiary, or enrollee and item or service''; and

(B) by striking paragraph (2) and inserting the following:

''(2) RECONCILIATION REQUIREMENT.—For purposes of paragraph (1), a group health plan, on a regular basis, shall reconcile payment requests for items or services furnished by a nonparticipating provider or a nonparticipating facility and the posted

provider directory database for the day the delivered item or service was provided. If a nonparticipating provider was listed as a participating provider in the directory, the group health plan shall notify the participant, beneficiary, or enrollee, in plain language, that the participant, beneficiary, or enrollee may be eligible for a refund from the group health plan if such participant, beneficiary, or enrollee paid the out of network cost-sharing and did not receive a refund under section 2799B–9(b) of the Public Health Service Act (42 U.S.C. 300gg–139).''.

SEC. 3. PROVIDER REQUIREMENTS TO PROTECT PATIENTS AND IMPROVE THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.

Section 2799B–9 of the Public Health Service Act (42 U.S.C. 300gg–139) is amended—

(1) in subsection (a)—

(A) in paragraph (3), by striking ''; and'' and inserting a semicolon;

(B) by redesignating paragraph (4) as paragraph (6); and

(C) by inserting after paragraph (3) the following:

''(4) subject to paragraph (5), when a provider or facility that is not accepting new patients deter-

mines that it has the ability to accept new patients, within 5 business days of such determination;

''(5) when a solo practitioner or small provider, as determined by the Secretary, determines that it has the ability to accept new patients, within 10 business days of such determination; and''; and

(2) by amending subsection (d) to read as follows:

''(d) DEFINITION.—For purposes of this section, the term 'provider directory information' includes—

''(1) the name, address, specialty, telephone number, and digital contact information of each individual health care provider contracted to participate in any of the networks of the group health plan or health insurance coverage involved;

''(2) the name, address, specialty, telephone number, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved; and

''(3) with respect to each such provider, medical group, clinic, or facility—

''(A) whether such provider, medical group, clinic, or facility is accepting new patients;

''(B) the languages spoken and the availability of language translators for specified languages at each provider, medical group, clinic, or facility listed in the directory;

''(C) whether the provider, medical group, clinic, or facility offers medication-assisted treatment for opioid use disorder;

''(D) the State license number;

''(E) the national provider identifier;

''(F) the age groups served by such provider, group, clinic, or facility, such as pediatric, adolescent, adult, or geriatric populations;

''(G) whether such provider, group, clinic, or facility offers in-person services, telehealth services, or both; and

''(H) the cost-sharing tier, if applicable.''.

SEC. 4. STRENGTHENING MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY REQUIREMENTS.

(a) PHSA.—

(1) NETWORK ADEQUACY REQUIREMENTS.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

''(9) NETWORK ADEQUACY REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue regulations establishing national quantitative standards for mental health and substance use disorder network adequacy. Such standards shall consider—

"(i) the ratio of in-network mental health providers, separated by professional type of mental health provider, to participants, beneficiaries, and enrollees in a group health plan or health insurance coverage;

"(ii) the ratio of in-network substance use disorder providers, separated by professional type of substance use disorder provider, to participants, beneficiaries, and enrollees in a group health plan or health insurance coverage;

"(iii) separately, for each of mental health services and substance use disorder services—

"(I) geographic accessibility of providers;

"(II) geographic variation and population dispersion;

''(III) waiting times for appointments with participating providers;

''(IV) hours of operation for participating providers;

''(V) the ability of the network to meet the needs of participants, beneficiaries, and enrollees, including low-income individuals, individuals who are members of a racial or ethnic minority, individuals who live in a health professional shortage area, children and adults with serious, chronic, and complex health conditions, individuals with physical or mental disabilities or substance use disorders, pediatric populations, and individuals with limited English proficiency;

''(VI) the availability of in-person services, telehealth services, and hybrid services to serve the needs of participants, beneficiaries, and enrollees; and

''(VII) the percentage of in-network providers who have submitted a

claim for payment during the previous 6 months; and

''(iv) other standards as determined by the Secretary, the Secretary of Labor, and the Secretary of the Treasury.

''(B) TIMING.—

''(i) ISSUANCE.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury shall—

''(I) issue proposed regulations required under subparagraph (A) not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act; and

''(II) issue final regulations under subparagraph (A) not later than 1 year thereafter.

''(ii) EFFECTIVE DATE.—The regulations promulgated under this paragraph shall take effect in the first plan year that begins after the date on which such final regulations are issued.

''(C) AUDITS.—The Secretary, the Secretary of Labor, and the Secretary of the

Treasury shall conduct annual, targeted audits of not fewer than 10 group health plans and health insurance issuers offering group or individual health insurance coverage that the Secretaries determine to be the subject of the greatest number of complaints about mental health and substance use disorder network adequacy to ensure compliance with the requirements of this paragraph. Such audits shall begin not earlier than one year after the final regulations implementing this paragraph begin to apply to group health plans and health insurance issuers.''.

(2) DEFINITIONS.—Paragraphs (4) and (5) of section 2726(e) of the Public Health Service Act (42 U.S.C. 300gg–26(e)) are amended to read as follows:

''(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to services related to a mental health condition, defined consistently with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

''(5) SUBSTANCE USE DISORDER BENEFITS.—The term 'substance use disorder benefits' means benefits with respect to services related to a substance use disorder, defined consistently with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.''.

(3) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)), as amended by paragraph (1), is further amended by adding at the end the following:

''(10) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary, the Secretary of Labor, and the Secretary of the Treasury shall issue regulations on a standard for parity in reimbursement rates for mental health or substance use disorder benefits and medical and surgical benefits, based on a comparative analysis conducted by such Secretaries using data submitted by

group health plans and health insurance issuers, provider associations, and other experts related to the cost of care delivery for mental health and substance use disorder benefits.

''(B) REQUESTS FOR DATA.—Group health plans and health insurance issuers shall comply with any request for data issued by the Secretary, the Secretary of Labor, and the Secretary of the Treasury for purposes of developing the standards under subparagraph (A).

''(C) EFFECTIVE DATE.—The regulations promulgated under subparagraph (A) shall apply to group health plans and health insurance issuers offering group or individual health insurance coverage beginning in the first plan year that begins after issuance of the final regulations.''.

(b) ERISA.—

(1) NETWORK ADEQUACY REQUIREMENTS.—Section 712(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)) is amended by adding at the end the following:

''(9) NETWORK ADEQUACY REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and

the Secretary of the Treasury shall issue regulations establishing national quantitative standards for mental health and substance use disorder network adequacy. Such standards shall consider—

''(i) the ratio of in-network mental health providers, separated by professional type of mental health provider, to participants, beneficiaries, and enrollees in a group health plan or health insurance coverage;

''(ii) the ratio of in-network substance use disorder providers, separated by professional type of substance use disorder provider, to participants, beneficiaries, and enrollees in a group health plan or health insurance coverage;

''(iii) separately, for each of mental health services and substance use disorder services—

''(I) geographic accessibility of providers;

''(II) geographic variation and population dispersion;

''(III) waiting times for appointments with participating providers;

''(IV) hours of operation for participating providers;

''(V) the ability of the network to meet the needs of participants, beneficiaries, and enrollees, including low-income individuals, individuals who are members of a racial or ethnic minority, individuals who live in a health professional shortage area, children and adults with serious, chronic, and complex health conditions, individuals with physical or mental disabilities or substance use disorders, pediatric populations, and individuals with limited English proficiency;

''(VI) the availability of in-person services, telehealth services, and hybrid services to serve the needs of participants, beneficiaries, and enrollees; and

''(VII) the percentage of in-network providers who have submitted a

claim for payment during the previous 6 months; and

''(iv) other standards as determined by the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury.

''(B) TIMING.—

''(i) ISSUANCE.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall—

''(I) issue proposed regulations required under subparagraph (A) not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act; and

''(II) issue final regulations under subparagraph (A) not later than 1 year thereafter.

''(ii) EFFECTIVE DATE.—The regulations promulgated under this paragraph shall take effect in the first plan year that begins after the date on which such final regulations are issued.

''(C) AUDITS.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall conduct annual, targeted audits of not fewer than 10 group health plans and health insurance issuers offering group health insurance coverage that the Secretaries determine to be the subject of the greatest number of complaints about mental health and substance use disorder network adequacy to ensure compliance with the requirements of this paragraph. Such audits shall begin not earlier than one year after the final regulations implementing this paragraph begin to apply to group health plans and health insurance issuers.''.

(2) DEFINITIONS.—Paragraphs (4) and (5) of section 712(e) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(e)) are amended to read as follows:

''(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to services related to a mental health condition, defined consistently with generally recognized independent standards of current medical practice, such

as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

''(5) SUBSTANCE USE DISORDER BENEFITS.—The term 'substance use disorder benefits' means benefits with respect to services related to a substance use disorder, defined consistently with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.''.

(3) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—Section 712(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)), as amended by paragraph (1), is further amended by adding at the end the following:

''(10) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall issue regulations on a standard for parity in reimbursement rates for mental health or substance use disorder benefits and

medical and surgical benefits, based on a comparative analysis conducted by such Secretaries using data submitted by group health plans and health insurance issuers, provider associations, and other experts related to the cost of care delivery for mental health and substance use disorder benefits.

''(B) REQUESTS FOR DATA.—Group health plans and health insurance issuers shall comply with any request for data issued by the Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury for purposes of developing the standards under subparagraph (A).

''(C) EFFECTIVE DATE.—The regulations promulgated under subparagraph (A) shall apply to group health plans and health insurance issuers offering group health insurance coverage beginning in the first plan year that begins after issuance of the final regulations.''.

(c) IRC.—

(1) NETWORK ADEQUACY REQUIREMENTS.—Section 9812(a) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(9) NETWORK ADEQUACY REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor shall issue regulations establishing national quantitative standards for mental health and substance use disorder network adequacy. Such standards shall consider—

"(i) the ratio of in-network mental health providers, separated by professional type of mental health provider, to participants, beneficiaries, and enrollees in a group health plan;

"(ii) the ratio of in-network substance use disorder providers, separated by professional type of substance use disorder provider, to participants, beneficiaries, and enrollees in a group health plan;

"(iii) separately, for each of mental health services and substance use disorder services—

"(I) geographic accessibility of providers;

"(II) geographic variation and population dispersion;

"(III) waiting times for appointments with participating providers;

''(IV) hours of operation for participating providers;

''(V) the ability of the network to meet the needs of participants, beneficiaries, and enrollees, including low-income individuals, individuals who are members of a racial or ethnic minority, individuals who live in a health professional shortage area, children and adults with serious, chronic, and complex health conditions, individuals with physical or mental disabilities or substance use disorders, pediatric populations, and individuals with limited English proficiency;

''(VI) the availability of in-person services, telehealth services, and hybrid services to serve the needs of participants, beneficiaries, and enrollees; and

''(VII) the percentage of in-network providers who have submitted a claim for payment during the previous 6 months; and

"(iv) other standards as determined by the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor.

"(B) TIMING.—

"(i) ISSUANCE.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor shall—

"(I) issue proposed regulations required under subparagraph (A) not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act; and

"(II) issue final regulations under subparagraph (A) not later than 1 year thereafter.

"(ii) EFFECTIVE DATE.—The regulations promulgated under this paragraph shall take effect in the first plan year that begins after the date on which such final regulations are issued.

"(C) AUDITS.—The Secretary, the Secretary of Health and Human Services, and the Secretary of Labor shall conduct annual, tar-

geted audits of not fewer than 10 group health plans that the Secretaries determine to be the subject of the greatest number of complaints about mental health and substance use disorder network adequacy to ensure compliance with the requirements of this paragraph. Such audits shall begin not earlier than one year after the final regulations implementing this paragraph begin to apply to group health plans.''.

(2) DEFINITIONS.—Paragraphs (4) and (5) of section 9812(e) of the Internal Revenue Code of 1986 are amended to read as follows:

''(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to services related to a mental health condition, defined consistently with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

''(5) SUBSTANCE USE DISORDER BENEFITS.—The term 'substance use disorder benefits' means benefits with respect to services related to a substance use disorder, defined consistently with generally recognized independent standards of current medical practice, such as the Diagnostic and Statis-

tical Manual of Mental Disorders of the American Psychiatric Association.''.

(3) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—Section 9812(a) of the Internal Revenue Code of 1986, as amended by paragraph (1), is further amended by adding at the end the following:

''(10) STANDARDS FOR PARITY IN REIMBURSEMENT RATES.—

''(A) IN GENERAL.—Not later than 2 years after the date of enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor shall issue regulations on a standard for parity in reimbursement rates for mental health or substance use disorder benefits and medical and surgical benefits, based on a comparative analysis conducted by such Secretaries using data submitted by group health plans, provider associations, and other experts related to the cost of care delivery for mental health and substance use disorder benefits.

''(B) REQUESTS FOR DATA.—Group health plans shall comply with any request for data

issued by the Secretary, the Secretary of Health and Human Services, and the Secretary of Labor for purposes of developing the standards under subparagraph (A).

''(C) EFFECTIVE DATE.—The regulations promulgated under subparagraph (A) shall apply to group health plans beginning in the first plan year that begins after issuance of the final regulations.''.

SEC. 5. STATE AND TRIBAL OMBUDSMAN PROGRAMS RELATING TO MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended—

(1) by redesignating section 2794 (42 U.S.C. 300gg–95) (regarding uniform fraud and abuse referral format), as added by section 6603 of the Patient Protection and Affordable Care Act (Public Law 111–148), as section 2795; and

(2) by adding at the end the following:

''SEC. 2796. STATE AND TRIBAL OMBUDSMAN PROGRAMS RELATING TO MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY.

''(a) IN GENERAL.—The Secretary shall make grants to eligible entities, designated by a State, Indian Tribe,

or Tribal organization, as described in subsection (b), for the purpose of—

"(1) establishing or supporting State and Tribal mental health and substance use disorder parity ombudsman programs to—

"(A) educate consumers about the mental health and substance use disorder coverage in individual plans, group health plans, self-insured plans, and State Medicaid managed care plans;

"(B) assist consumers in understanding their rights as health benefits plan members, including appeal processes and how to use such benefits, and how to access appropriate medical information;

"(C) assist consumers in exercising their rights under the provisions of part D, including resolving problems related to a group health plan or health insurance issuer erroneously charging a consumer out-of-network rates for services listed in-network on the group health plan or health insurance issuer's provider directory;

"(D) identify, investigate, and help resolve complaints related to mental health and sub-

stance use disorder coverage (including potential violations of the mental health and substance use disorder parity laws) on behalf of consumers;

''(E) maintain a toll-free hotline and website for consumers;

''(F) collect, track, and quantify problems and inquiries encountered by consumers; and

''(G) other activities as defined by the Secretary; and

''(2) provide support and training for such State and Tribal mental health parity ombudsman programs (such as through the establishment of a mental health parity ombudsman program resource center).

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section, a State, Indian Tribe, or Tribal organization shall designate an ombudsman or consumer assistance program or other independent entity that—

''(1) has specialized knowledge of mental health conditions and substance use disorders and experience resolving inquiries and complaints; and

''(2) directly, or in coordination with departments of insurance, and consumer assistance organizations, receives and responds to inquiries and com-

plaints concerning access to mental health and substance use disorder services.

''(c) CRITERIA.—A State, Indian Tribe, or Tribal organization that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

''(d) DATA COLLECTION.—As a condition of receiving a grant, an eligible entity shall agree to—

''(1) collect and report data to the Secretary, State legislature, and relevant State agencies, including the departments of insurance and the State attorney general, on the numbers and types of problems and inquiries encountered by individuals with respect to access to behavioral health services; and

''(2) report to the Secretary on how identified problems were addressed, including through promising practices related to responding to mental health and substance use disorder coverage issues, including appeals and education.

''(e) REPORT TO CONGRESS.—Not later than 4 years after the date of the enactment of the Behavioral Health Network and Directory Improvement Act, the Secretary shall submit to Congress a report on the data collected under subsection.

''(f) DEFINITIONS.—In this section, the terms 'Indian Tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Self-Determination and Education Assistance Act.

''(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $20,000,000 for fiscal year 2024 and $10,000,000 for fiscal year 2025 and each fiscal year thereafter.''.

SEC. 6. REPORT TO CONGRESS.

(a) IN GENERAL.—Not later than 6 years after the date of enactment of this Act and every 2 years for the next 10 years, the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury (collectively referred to in this section as the ''Secretaries'') shall jointly submit to Congress and make publicly available a report to assess the prevalence of ghost networks and the adequacy of mental health and substance use disorder networks, in accordance with section 2726(a)(9) of the Public Health Service Act, section 712(a)(9) of the Employee Retirement Income Security Act of 1974, and section 9812(a)(9) of the Internal Revenue Code of 1986, as amended by section 4. Such report shall include the following:

(1) Aggregate information about group health plans and health insurance issuers determined by

the Secretaries to be out of compliance with the provider directory requirements under section 2799A–5 of the Public Health Service Act, section 720 of the Employee Retirement Income Security Act of 1974, and section 9820 of the Internal Revenue Code of 1986, as amended by section 2.

(2) Aggregate information about group health plans and health insurance issuers determined by the Secretaries to be out of compliance with the requirements for parity in mental health and substance use disorder benefits under section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26), section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a), and section 9812 of the Internal Revenue Code of 1986, as amended by section 4.

(3) A summary of findings through audits, in the aggregate, under section 2799A–5(a)(7)(C) of the Public Health Service Act, section 720(a)(7)(C) of the Employee Retirement Income Security Act of 1974, and section 9820(a)(7)(C) of the Internal Revenue Code of 1986, as amended by section 2, including—

(A) the provider directory accuracy rating assigned by the Secretaries;

(B) the accuracy of provider directory information, sectioned out by accuracy of the provider's name, address, specialty, telephone number, digital contact information, whether the providers are accepting new patients, in-network status, linguistic- and cultural-competency, and availability of medications for opioid use disorder;

(C) the number of plans and individuals enrolled in a group health plan or group or individual health insurance coverage that offers a mental health and substance use disorder network that meets the network adequacy standards under, as applicable, section 2799A–5 of the Public Health Service Act, section 720 of the Employee Retirement Income Security Act of 1974, or section 9820 of the Internal Revenue Code of 1986, as amended by section 2; and

(D) the number of individuals enrolled in a group health plan or group or individual health insurance coverage with a ghost network.

(4) A comparative analysis of in-network and out-of-network reimbursement rates for mental health and substance use disorder services compared

to medical and surgical services by group health plans and health insurance issuers.

(b) DEFINITION.—In this section, the term ''ghost network'' has the meaning given such term in section 2799A–5(a)(8) of the Public Health Service Act, section 720(a)(8) of the Employee Retirement Income Security Act of 1974, and section 9820(a)(8) of the Internal Revenue Code of 1986, as amended by section 2.

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

To carry out this Act, including the amendments made by this Act, in addition to amounts otherwise made available for such purposes, there are authorized to be appropriated $28,000,000 for each of fiscal years 2023 through 2032.

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