117TH CONGRESS
2D SESSION

S. 4616

To amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to strengthen parity in mental health and substance use disorder benefits.

IN THE SENATE OF THE UNITED STATES

JULY 26, 2022

Ms. WARREN (for herself, Ms. BALDWIN, Mr. BLUMENTHAL, Mr. BOOKER, Mr. BROWN, Mr. KAINE, Ms. KLOBUCHAR, Mr. LUJÁN, Mr. MARKEY, Mr. MURPHY, Mr. SANDERS, Ms. SMITH, Ms. STABENOW, and Mr. VAN HOLLEN) 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 amend title XXVII of the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to strengthen parity in mental health and substance use disorder benefits.

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 Coverage Transparency Act of 2022''.

SEC. 2. STRENGTHENING PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) PUBLIC HEALTH SERVICE ACT.—Section 2726(a)(8) of the Public Health Service Act (42 U.S.C. 300gg–26(a)(8)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ''(including entities that provide administrative services in connection with a group health plan, such as third party administrators)'' after ''insurance coverage''; and

(B) by striking ''and, beginning 45 days after'' and all that follows through ''upon request,'' and inserting ''and submit to the Secretary (or the Secretary of Labor or the Secretary of the Treasury, as applicable), on an annual basis (and at any other time upon request of the Secretary), and to the applicable State authority upon request,'';

(2) in subparagraph (B)—

(A) in the heading, by striking ''REQUEST'' and inserting ''REVIEW'';

(B) in clause (i)—

(i) in the heading, by striking ''SUBMISSION UPON REQUEST'' and inserting ''IN GENERAL'';

(ii) by striking ''shall request'' and all that follows through ''coverage submit'' and insert ''shall conduct a review of''; and

(iii) by striking ''shall request not fewer than 20'' and inserting ''shall conduct a review of not fewer than 60'';

(C) in clause (ii)—

(i) in the first sentence, by striking ''as requested under clause (i)'' and inserting ''as submitted under such subparagraph'';

(ii) in the first sentence, by striking ''to be responsive to the request under clause (i) for'' and inserting ''to enable''; and

(iii) in the second sentence, by striking '', as requested under clause (i)'';

(D) in clause (iii)—

(i) in subclause (I), by striking '', as requested under clause (i),''; and

(ii) by adding at the end of subclause (II) the following new sentence: ''The pre-

ceding sentence shall not apply with respect to disclosures made on or after the date of the enactment of this sentence.''; and

(E) in clause (iv)—

(i) in subclause (I)—

(I) by striking ''requested under clause (i)'' and inserting ''reviewed under clause (i)''; and

(II) by striking ''after the final determination by the Secretary described in clause (iii)(I)(bb)'' and inserting ''by the Secretary as described in clause (iii)(I)'';

(ii) in subclause (II), by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses'';

(iii) in subclause (III), by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses'';

(iv) in subclause (IV)—

(I) by striking ''the comparative analyses requested under clause (i)''

and inserting ''such comparative analyses''; and

(II) by striking ''and'' at the end;

(v) in subclause (V), by striking the period and inserting a semicolon; and

(vi) by adding at the end the following:

''(VI) the name of each group health plan or health insurance issuer found not to have submitted comparative analyses in accordance with subparagraph (A);

''(VII) the name of each group health plan or health insurance issuer whose comparative analyses were reviewed under clause (i) and found not to have submitted sufficient information for the Secretary to review; and

''(VIII) the name of any plan or coverage with respect to which a complaint has been submitted under subparagraph (C) and for which a final review finding has been issued.

The requirements of this clause with respect to plans or issuers shall also apply to

entities that provide administrative services in connection with a group health plan, such as third party administrators, if applicable.'';

(3) in subparagraph (C)(i), by striking ''requested''; and

(4) by adding at the end the following new subparagraphs:

''(D) AUDIT PROCESS.—Beginning 1 year after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, as applicable, shall, in addition to conducting reviews in accordance with subparagraph (B), conduct randomized audits of group health plans, health insurance issuers offering group or individual health insurance coverage, and entities that provide administrative services in connection with a group health plan, such as third party administrators, to determine compliance with this section. Such audits shall be conducted on no fewer than 40 plans or coverages per calendar year (not including any reviews conducted under such subparagraph). In addition, the Secretary may, in cooperation with the Sec-

retaries of Labor and the Treasury, as applicable, and in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, as applicable, conduct audits on any such plan or coverage with respect to which a complaint has been submitted under subparagraph (E) to determine compliance with this section.

''(E) COMPLAINT PROCESS.—Not later than 6 months after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretary of Labor and the Secretary of the Treasury, shall, with respect to group health plans and health insurance issuers offering group or individual health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators), issue guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to such

plans and coverage to file formal complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, and national offices with which such complaints should be filed.

''(F) COVERAGE DISPARITY INFORMATION.—For the first calendar year that begins on or after the date that is 2 years after the date of the enactment of this subparagraph, and for each subsequent calendar year, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the following information with respect to the preceding calendar year:

''(i) DENIAL RATES.—Data comparing the rates of and reasons for denial by group health plans and health insurance issuers offering group or individual health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) of claims for

mental health benefits, substance use disorder benefits, and medical and surgical benefits, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.

''(ii) NETWORK ADEQUACY DATA.—Data comparing the network adequacy of group health plans and health insurance issuers offering group or individual health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) based on claims for outpatient and inpatient mental health benefits, substance use disorder benefits, and medical and surgical benefits, including out-of-network utilization rates,

the number and percentage of in-network providers accepting new patients, and average wait times between receiving initial treatment and diagnosis and follow-up treatment.

''(iii) REIMBURSEMENT RATES.—Data comparing the reimbursement rates of group health plans and health insurance issuers offering group or individual health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) for the 10 most commonly billed mental health services, substance use services, and medical and surgical services, each as a percentage of rates payable for such services under title XVIII of the Social Security Act, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Section 712(a)(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)(8)) is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ''(including entities that provide administrative services in connection with a group health plan, such as third party administrators)'' after ''insurance coverage''; and

(B) by striking ''and, beginning 45 days after'' and all that follows through ''upon request,'' and inserting ''and submit to the Secretary (or the Secretary of Health and Human Services or the Secretary of the Treasury, as applicable), on an annual basis (and at any other time upon request of the Secretary),'';

(2) in subparagraph (B)—

(A) in the heading, by striking ''REQUEST'' and inserting ''REVIEW'';

(B) in clause (i)—

(i) in the heading, by striking ''SUBMISSION UPON REQUEST'' and inserting ''IN GENERAL'';

(ii) by striking ''shall request'' and all that follows through ''coverage submit'' and insert ''shall conduct a review of''; and

(iii) by striking ''shall request not fewer than 20'' and inserting ''shall conduct a review of not fewer than 60'';

(C) in clause (ii)—

(i) in the first sentence, by striking ''as requested under clause (i)'' and inserting ''as submitted under such subparagraph'';

(ii) in the first sentence, by striking ''to be responsive to the request under clause (i) for'' and inserting ''to enable''; and

(iii) in the second sentence, by striking '', as requested under clause (i)'';

(D) in clause (iii)—

(i) in subclause (I), by striking '', as requested under clause (i),''; and

(ii) by adding at the end of subclause (II) the following new sentence: ''The preceding sentence shall not apply with respect to disclosures made on or after the date of the enactment of this sentence.''; and

(E) in clause (iv)—

(i) in subclause (I)—

(I) by striking ''requested under clause (i)'' and inserting ''reviewed under clause (i)''; and

(II) by striking ''after the final determination by the Secretary described in clause (iii)(I)(bb)'' and inserting ''by the Secretary as described in clause (iii)(I)'';

(ii) in subclause (II), by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses'';

(iii) in subclause (III), by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses'';

(iv) in subclause (IV)—

(I) by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses''; and

(II) by striking ''and'' at the end;

(v) in subclause (V), by striking the period and inserting a semicolon; and

(vi) by adding at the end the following:

''(VI) the name of each group health plan or health insurance issuer found not to have submitted comparative analyses in accordance with subparagraph (A);

''(VII) the name of each group health plan or health insurance issuer whose comparative analyses were reviewed under clause (i) and found not to have submitted sufficient information for the Secretary to review; and

''(VIII) the name of any plan or coverage with respect to which a complaint has been submitted under subparagraph (C) and for which a final review finding has been issued.

The requirements of this clause with respect to plans or issuers shall also apply to entities that provide administrative services in connection with a group health plan, such as third party administrators, if applicable.'';

(3) in subparagraph (C)(i), by striking ''requested''; and

(4) by adding at the end the following new subparagraphs:

''(D) AUDIT PROCESS.—Beginning 1 year after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, as applicable, shall, in addition to conducting reviews in accordance with subparagraph (B), conduct randomized audits of group health plans, health insurance issuers offering group health insurance coverage, and entities that provide administrative services in connection with a group health plan, such as third party administrators, to determine compliance with this section. Such audits shall be conducted on no fewer than 40 plans or coverages per calendar year (not including any reviews

conducted under such subparagraph). In addition, the Secretary may, in cooperation with the Secretaries of Health and Human Services and the Treasury, as applicable, and in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, as applicable, conduct audits on any such plan or coverage with respect to which a complaint has been submitted under subparagraph (E) to determine compliance with this section.

''(E) COMPLAINT PROCESS.—Not later than 6 months after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretary of Health and Human Services and the Secretary of the Treasury, shall, with respect to group health plans and health insurance issuers offering group health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators), issue guidance to clarify the process and timeline for current and potential partici-

pants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to such plans and coverage to file formal complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State, regional, and national offices with which such complaints should be filed.

''(F) COVERAGE DISPARITY INFORMATION.—For the first calendar year that begins on or after the date that is 2 years after the date of the enactment of this subparagraph, and for each subsequent calendar year, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the following information with respect to the preceding calendar year:

''(i) DENIAL RATES.—Data comparing the rates of and reasons for denial by group health plans and health insurance

issuers offering group health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) of claims for mental health benefits, substance use disorder benefits, and medical and surgical benefits, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.

''(ii) NETWORK ADEQUACY DATA.—Data comparing the network adequacy of group health plans and health insurance issuers offering group health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) based on claims for out-

patient and inpatient mental health benefits, substance use disorder benefits, and medical and surgical benefits, including out-of-network utilization rates, the number and percentage of in-network providers accepting new patients, and average wait times between receiving initial treatment and diagnosis and follow-up treatment.

''(iii) REIMBURSEMENT RATES.—Data comparing the reimbursement rates of group health plans and health insurance issuers offering group health insurance coverage (including entities that provide administrative services in connection with a group health plan, such as third party administrators) for the 10 most commonly billed mental health services, substance use services, and medical and surgical services, each as a percentage of rates payable for such services under title XVIII of the Social Security Act, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.''.

(c) INTERNAL REVENUE CODE OF 1986.—Section 9812(a)(8) of the Internal Revenue Code of 1986 is amended—

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ''(including entities that provide administrative services in connection with a group health plan, such as third party administrators)'' after ''In the case of a group health plan''; and

(B) by striking ''and, beginning 45 days after'' and all that follows through ''upon request,'' and inserting ''and submit to the Secretary (or the Secretary of Health and Human Services or the Secretary of Labor, as applicable), on an annual basis (and at any other time upon request of the Secretary),'';

(2) in subparagraph (B)—

(A) in the heading, by striking ''REQUEST'' and inserting ''REVIEW'';

(B) in clause (i)—

(i) in the heading, by striking ''SUBMISSION UPON REQUEST'' and inserting ''IN GENERAL'';

(ii) by striking ''shall request'' and all that follows through ''plan submit'' and insert ''shall conduct a review of''; and

(iii) by striking ''shall request not fewer than 20'' and inserting ''shall conduct a review of not fewer than 60'';

(C) in clause (ii)—

(i) in the first sentence, by striking ''as requested under clause (i)'' and inserting ''as submitted under such subparagraph'';

(ii) in the first sentence, by striking ''to be responsive to the request under clause (i) for'' and inserting ''to enable''; and

(iii) in the second sentence, by striking '', as requested under clause (i)'';

(D) in clause (iii)—

(i) in subclause (I), by striking '', as requested under clause (i),''; and

(ii) by adding at the end of subclause (II) the following new sentence: ''The preceding sentence shall not apply with respect to disclosures made on or after the date of the enactment of this sentence.''; and

(E) in clause (iv)—

(i) in subclause (I)—

(I) by striking ''requested under clause (i)'' and inserting ''reviewed under clause (i)''; and

(II) by striking ''after the final determination by the Secretary described in clause (iii)(I)(bb)'' and inserting ''by the Secretary as described in clause (iii)(I)'';

(ii) in subclause (II), by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses'';

(iii) in subclause (III), by striking ''the comparative analyses requested under

clause (i)'' and inserting ''such comparative analyses'';

(iv) in subclause (IV)—

(I) by striking ''the comparative analyses requested under clause (i)'' and inserting ''such comparative analyses''; and

(II) by striking ''and'' at the end;

(v) in subclause (V), by striking the period and inserting a semicolon; and

(vi) by adding at the end the following:

''(VI) the name of each group health plan found not to have submitted comparative analyses in accordance with subparagraph (A);

''(VII) the name of each group health plan whose comparative analyses were reviewed under clause (i) and found not to have submitted sufficient information for the Secretary to review; and

''(VIII) the name of any plan with respect to which a complaint has been submitted under subparagraph

(C) and for which a final review finding has been issued.

The requirements of this clause with respect to plans shall also apply to entities that provide administrative services in connection with a group health plan, such as third party administrators, if applicable.'';

(3) in subparagraph (C)(i), by striking ''requested''; and

(4) by adding at the end the following new subparagraphs:

''(D) AUDIT PROCESS.—Beginning 1 year after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and Labor, as applicable, shall, in addition to conducting reviews in accordance with subparagraph (B), conduct randomized audits of group health plans and entities that provide administrative services in connection with a group health plan, such as third party administrators, to determine compliance with this section. Such audits shall be conducted on no fewer than 40 plans per calendar year (not including any reviews conducted under such subparagraph). In

addition, the Secretary may, in cooperation with the Secretaries of Health and Human Services and Labor, as applicable, and in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, as applicable, conduct audits on any such plan with respect to which a complaint has been submitted under subparagraph (E) to determine compliance with this section.

''(E) COMPLAINT PROCESS.—Not later than 6 months after the date of enactment of this subparagraph, the Secretary, in cooperation with the Secretary of Health and Human Services and the Secretary of Labor, shall, with respect to group health plans (including entities that provide administrative services in connection with a group health plan, such as third party administrators), issue guidance to clarify the process and timeline for current and potential participants and beneficiaries (and authorized representatives and health care providers of such participants and beneficiaries) with respect to such plans to file formal complaints of

such plans being in violation of this section, including guidance, by plan type, on the relevant State, regional, and national offices with which such complaints should be filed.

''(F) COVERAGE DISPARITY INFORMATION.—For the first calendar year that begins on or after the date that is 2 years after the date of the enactment of this subparagraph, and for each subsequent calendar year, the Secretary, in cooperation with the Secretaries of Health and Human Services and Labor, shall submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the following information with respect to the preceding calendar year:

''(i) DENIAL RATES.—Data comparing the rates of and reasons for denial by group health plans (including entities that provide administrative services in connection with a group health plan, such as third party administrators) of claims for mental health benefits, substance use disorder benefits, and medical and surgical

benefits, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.

''(ii) NETWORK ADEQUACY DATA.—Data comparing the network adequacy of group health plans (including entities that provide administrative services in connection with a group health plan, such as third party administrators) based on claims for outpatient and inpatient mental health benefits, substance use disorder benefits, and medical and surgical benefits, including out-of-network utilization rates, the number and percentage of in-network providers accepting new patients, and average wait times between receiving initial

treatment and diagnosis and follow-up treatment.

''(iii) REIMBURSEMENT RATES.—Data comparing the reimbursement rates of group health plans (including entities that provide administrative services in connection with a group health plan, such as third party administrators) for the 10 most commonly billed mental health services, substance use services, and medical and surgical services, each as a percentage of rates payable for such services under title XVIII of the Social Security Act, disaggregated by the following categories:

''(I) Inpatient, in-network claims.

''(II) Inpatient, out-of-network claims.

''(III) Outpatient, in-network claims.

''(IV) Outpatient, out-of-network claims.

''(V) Emergency services.

''(VI) Prescription drug claims.''.

SEC. 3. CONSUMER PARITY UNIT FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY VIOLATIONS.

(a) DEFINITIONS.—In this section:

(1) APPLICABLE STATE AUTHORITY.—The term ''applicable State authority'' has the meaning given the term in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

(2) COVERED PLAN.—The term ''covered plan'' means any creditable coverage that is subject to any of the mental health parity laws described in paragraph (4).

(3) CREDITABLE COVERAGE.—The term ''creditable coverage'' has the meaning given the term in section 2704(c) of the Public Health Service Act (42 U.S.C. 300gg–3(c)).

(4) MENTAL HEALTH PARITY LAW.—The term ''mental health parity law'' means—

(A) section 2726 of the Public Health Service Act (42 U.S.C. 300gg–26);

(B) section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a);

(C) section 9812 of the Internal Revenue Code of 1986; or

(D) any other Federal law that applies the requirements under any of the sections described in subparagraph (A), (B), or (C), or requirements that are substantially similar to the requirements under any such section, as determined by the Secretary, to creditable coverage.

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) SPECIFIED COVERED PLAN.—The term ''specified covered plan'' means a covered plan that is any of the following:

(A) A group health plan or group or individual health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)).

(B) A Medicare Advantage plan offered under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(C) A State plan (or waiver of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(D) A plan offered under the program established under chapter 89 of title 5, United States Code.

(b) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall establish a consumer parity unit with functions that include—

(1) facilitating the centralized collection of, monitoring of, and response to consumer complaints (including provider complaints) regarding violations of mental health parity laws through developing and administering, in accordance with subsection (d)—

(A) a single, toll-free telephone number; and

(B) a public website portal, which may include enhancing a website portal in existence on the date of enactment of this Act; and

(2) providing information to health care consumers regarding the disclosure requirements and enforcement under section 2726(a)(8) of the Public Health Service Act (42 U.S.C. 300gg–26(a)(8)), section 712(a)(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a(a)(8)), and section 9812(a)(8) of the Internal Revenue Code of 1986.

(c) WEBSITE PORTAL.—The Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall make available on the website portal established under subsection (b)(1)(B)—

(1) any guidance and any reports issued by the Secretary, the Secretary of Labor, or the Secretary of the Treasury, 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), or section 9812 of the Internal Revenue Code of 1986, respectively;

(2) any information obtained under subsection (b)(1) that it is in the public interest to disclose, through aggregated reported or other appropriate formats designed to protect confidential information in accordance with subsection (g); and

(3) information on the results of, or progress on, any concluded or ongoing audits or investigations of the Secretary, the Secretary of Labor, or the Secretary of the Treasury, as applicable, under such section 2726, 712, or 9812, respectively, including the identity of each group health plan or health insurance issuer (including entities that provide administrative services in connection with a group

health plan, such as third party administrators) that—

(A) was the subject of a concluded audit or investigation; or

(B) that is the subject of an ongoing audit or investigation and which was found, pursuant to such audit or investigation, not to have submitted NQTL analyses in accordance with such sections (or to have submitted incomplete NQTL analyses).

(d) RESPONSE TO CONSUMER COMPLAINTS AND INQUIRIES.—

(1) TIMELY RESPONSE TO CONSUMERS.—The Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall establish reasonable procedures for the consumer parity unit established under this section to provide a response (in writing if appropriate) within 90 days to consumers regarding complaints received by the unit against, or inquiries concerning, a covered plan, at the discretion of the applicable agency, which shall at minimum include—

(A) steps that have been taken by the appropriate State or Federal enforcement agency

in response to the complaint or inquiry of the consumer;

(B) in the case such complaint relates to a specified covered plan, any responses received by the appropriate State or Federal enforcement agency from the covered plan;

(C) any follow-up actions or planned follow-up actions by the appropriate State or Federal enforcement agency in response to the complaint or inquiry of the consumer; and

(D) contact information of the appropriate enforcement agency for the consumer to obtain additional information on the complaint or inquiry.

(2) TIMELY RESPONSE TO REGULATORS.—A specified covered plan shall provide a response (in writing if appropriate) within 7 days to the appropriate State or Federal enforcement agency having jurisdiction over such plan (or, in the case such plan is a State plan (or wavier of such plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), to the Secretary of Health and Human Services) concerning a consumer complaint or inquiry submitted to the consumer parity unit established under this section including—

(A) steps that have been taken by the plan to respond to the complaint or inquiry of the consumer;

(B) any responses received by the plan from the consumer; and

(C) follow-up actions or planned follow-up actions by the plan in response to the complaint or inquiry of the consumer.

(3) PROVISION OF INFORMATION TO CONSUMERS.—

(A) IN GENERAL.—A covered plan shall comply with a consumer request for information in the control or possession of such covered plan concerning the coverage the consumer obtained from such covered plan within 7 days of receipt of such request.

(B) EXCEPTIONS.—Notwithstanding subparagraph (A), a covered plan, and any agency or entity having jurisdiction over a covered plan, may not be required by this paragraph to make available to the consumer any information required to be kept confidential by any other provision of law.

(4) ENFORCEMENT.—

(A) PRIVATE INSURANCE.—The provisions of paragraphs (2) and (3) shall apply to group health plans and group and individual health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91)) as if such provisions were included in part D of title XXVII of such Act (42 U.S.C. 300g–111 et seq.), part 7 of title I of the Employee Retirement Act of 1974 (29 U.S.C. 1181 et seq.), and chapter 100 of the Internal Revenue Code of 1986.

(B) OTHER SPECIFIED COVERED PLANS.—

(i) MEDICARE ADVANTAGE PLANS.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new section:

''(o) APPLICATION OF CERTAIN MENTAL HEALTH PARITY COMPLAINT REQUIREMENTS.—An MA plan shall comply with the requirements of paragraphs (2) and (3) of section 3(d) of the Behavioral Health Coverage Transparency Act of 2022.''.

(ii) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(I) in paragraph (86), by striking ''; and'' at the end;

(II) in paragraph (87)(D), by striking the period and inserting ''; and''; and

(III) by inserting after paragraph (87) the following new paragraph:

''(88) provide for compliance with the provisions of paragraphs (2) and (3) of section 3(d) of the Behavioral Health Coverage Transparency Act of 2022.''.

(C) OTHER COVERED PLANS.—In the case of a covered plan that is not a specified covered plan, the Federal agency charged with the administration or supervision of such plan shall ensure that such plan complies with the provisions of paragraph (3).

(e) REPORTS.—

(1) IN GENERAL.—Not later than December 31 of each year, the Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall submit a report to Congress on the complaints received by the consumer parity unit established under

this section in the prior year regarding covered plans.

(2) CONTENTS.—Each such report shall include information and analysis about complaint numbers, complaint types, and, where applicable, information about the resolution of complaints, including the identity of the group health plan or health insurance issuer that is the subject of such a complaint.

(3) CONSUMER PARITY UNIT POSTING.—The Secretary shall submit such reports to the consumer parity unit established under this section, and such unit shall post the reports on the website portal established under subsection (b)(1)(B).

(f) DATA SHARING.—Subject to any applicable standards for Federal or State agencies with respect to protecting personally identifiable information and data security and integrity, including the regulations under part 2 of title 42, Code of Federal Regulations—

(1) the consumer parity unit established under this section shall share consumer complaint information with the Secretary, and the head of any other applicable Federal or State agency; and

(2) the Secretary, and the head of any other applicable Federal or State agency, shall share data

relating to consumer complaints regarding covered plans with such unit.

(g) PRIVACY CONSIDERATIONS.—

(1) IN GENERAL.—In carrying out this section, the consumer parity unit established under this section and the Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the head of any other applicable agency, shall take measures to ensure that proprietary, personal, or confidential consumer information that is protected from public disclosure under section 552(b) or 552a of title 5, United States Code, or any other provision of law, is not made public under this section.

(2) EXCEPTIONS.—The consumer parity unit established under this section may not obtain from a covered plan any personally identifiable information about a consumer from the records of the covered plan, except—

(A) if the records are reasonably described in a request by the consumer parity unit established under this section, and the consumer provides appropriate consent for the disclosure and use of such information by the covered plan to such unit; or

(B) as may be specifically permitted or required under other applicable provisions of law, including the regulations under part 2 of title 42, Code of Federal Regulations.

(h) COLLABORATION.—

(1) AGREEMENTS WITH OTHER AGENCIES.—The Secretary, the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall enter into a memorandum of understanding with any affected Federal regulatory agency regarding procedures by which any covered plan, and any other agency having jurisdiction over a covered plan, shall comply with this section.

(2) AGREEMENTS WITH STATES.—To the extent practicable, an applicable State authority may receive appropriate complaints from the consumer parity unit established under this section, if—

(A) the applicable State authority has the functional capacity to receive calls or electronic reports routed by the unit;

(B) the applicable State authority has satisfied any conditions of participation that the unit may establish, including treatment of personally identifiable information and sharing of

information on complaint resolution or related compliance procedures and resources; and

(C) participation by the applicable State authority includes measures necessary to protect personally identifiable information in accordance with standards that apply to Federal agencies with respect to protecting personally identifiable information and data security and integrity.

(3) ASSISTANCE TO STATES.—The Secretary, the Secretary of Labor, the Secretary of the Treasury, and the heads of any other applicable agencies, shall provide assistance to States to increase the capacity of State governments to work with the Federal parity unit under this section, including through the provision of training and technical assistance, and identification of violations of mental health and substance use disorder parity protections.

(i) FUNDING.—

(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available until expended.

(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

SEC. 4. GRANTS FOR HEALTH INSURANCE INFORMATION CONCERNING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to States to enable such States (or the Exchanges established under the Patient Protection and Affordable Care Act (Public Law 111–148) operating in such States) to establish, expand, or provide support for—

(1) offices of health insurance consumer assistance; or

(2) health insurance ombudsman programs,

in order to enable such offices and programs to carry out the activities described in subsection (c).

(b) ELIGIBILITY.—

(1) IN GENERAL.—To be eligible to receive a grant, a State shall designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State

private and public health insurance regulators and consumer assistance organizations, receives and responds to inquiries and complaints concerning health insurance coverage with respect to Federal health insurance requirements and under State law relating to mental health or substance use disorder benefits.

(2) CRITERIA.—A State that receives a grant under this section shall comply with criteria established by the Secretary for carrying out activities under such grant.

(c) USE OF FUNDS.—Funds received from a grant awarded under this section shall be used by an office of health insurance consumer assistance or health insurance ombudsman described in subsection (a) to—

(1) assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer, Medicaid program, and Children's Health Insurance Program involved, relating to mental health or substance use disorder benefits, and providing information about the external appeal process;

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

(3) educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage, Medicaid, and Children's Health Insurance Program relating to mental health or substance use disorder benefits;

(4) assist consumers with enrollment in a group health plan or health insurance coverage, Medicaid, and the Children's Health Insurance Program by providing information, referral, and assistance; and

(5) assist consumers in resolving problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986 by providing information, referral, and assistance.

(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary and State public and private health insurance regulators on the types of problems and inquiries encountered by consumers relating to mental health or substance use disorder benefits. The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the

Treasury for use in the enforcement activities of such agencies.

(e) FUNDING.—

(1) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $25,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available until expended.

(2) AUTHORIZATION FOR SUBSEQUENT YEARS.—There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

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