

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

A BILL

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

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Behavioral Health Net-
5 work and Directory Improvement Act”.

6 **SEC. 2. PROTECTING PATIENTS AND IMPROVING THE AC-**
7 **CURACY OF PROVIDER DIRECTORY INFOR-**
8 **MATION.**

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

1 (1) in subsection (a)—

2 (A) in paragraph (1)—

3 (i) by striking “For plan years begin-
4 ning on or after January 1, 2022, each”
5 and inserting “Each”;

6 (ii) in subparagraph (C), by striking
7 “; and” and inserting a semicolon;

8 (iii) in subparagraph (D), by striking
9 the period and inserting “; and”; and

10 (iv) by adding at the end the fol-
11 lowing:

12 “(E) ensure that any directory, including
13 the database described in subparagraph (C),
14 containing provider directory information with
15 respect to such plan or such coverage complies
16 with the requirements developed by the appro-
17 priate agencies in accordance with paragraph
18 (6) in order to ensure that participants, bene-
19 ficiaries, and enrollees are able to identify ac-
20 tively participating health care providers and
21 health care facilities.”;

22 (B) in paragraph (2)(A), by striking “90
23 days” and inserting “30 days”;

24 (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

1 and Directory Improvement Act, issue interim
 2 final regulations (without prior notice and com-
 3 ment as required under section 553 of title 5,
 4 United States Code) further defining the term
 5 ‘ghost network’ (as defined in paragraph (8));
 6 and

7 “(B) not later than 18 months after the
 8 date of enactment of the Behavioral Health
 9 Network and Directory Improvement Act, issue
 10 interim final regulations (without prior notice
 11 and comment as required under section 553 of
 12 title 5, United States Code), subregulatory
 13 guidance, or program instruction on how to as-
 14 sess ghost networks in health plan directories
 15 including reasonable assumptions related to sta-
 16 tistics and research methods.

17 “(7) DATABASE REPORTING AND AUDITING TO
 18 PROTECT AGAINST GHOST NETWORKS.—

19 “(A) REPORTING REQUIREMENTS.—Begin-
 20 ning not later than 3 years after the date of en-
 21 actment of the Behavioral Health Network and
 22 Directory Improvement Act, each group health
 23 plan and health insurance issuer offering group
 24 or individual health insurance coverage shall
 25 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 fac-
tors 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 reason-
able sample in order to as-
sess provider directory infor-
mation accuracy; and

“(BB) determining the
criteria of an eligible audi-
tor.

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

1 “(aa) A list of every health
2 care provider and health care fa-
3 cility that was part of the net-
4 work of the applicable plan or
5 coverage, the months during the
6 plan year during which each such
7 provider or facility was part of
8 the network, and the number of
9 participants, beneficiaries, and
10 enrollees in the plan or coverage
11 (including participants, bene-
12 ficiaries, and enrollees who are
13 new patients of the provider)
14 each such provider or facility
15 treated during such period.

16 “(bb) The proportion of di-
17 rectory listings of the plan or
18 coverage with inaccurate infor-
19 mation, including incorrect con-
20 tact information, including incor-
21 rect contact information, as spec-
22 ified by the Secretary, during the
23 audit period.

24 “(cc) The number of in-net-
25 work items or services paid on

1 behalf of participants, bene-
2 ficiaries, and enrollees in the plan
3 or coverage to providers or facili-
4 ties who have a network provider
5 contract with the health plan or
6 issuer and were not listed in the
7 directory of the health plan or
8 health insurance coverage for the
9 audit period.

10 “(dd) The resources of the
11 plan or issuer to help partici-
12 pants, beneficiaries, and enrollees
13 locate an accurately listed in-net-
14 work provider who is accepting
15 new patients.

16 “(ee) The proportion of par-
17 ticipants, beneficiaries, and en-
18 rollees using out-of-network pro-
19 viders for mental health and sub-
20 stance use disorder services, and
21 the proportion of participants,
22 beneficiaries, and enrollees using
23 out-of-network providers and fa-
24 cilities for medical and surgical
25 services.

1 “(ff) Documentation that
2 the plan or issuer verifies the ac-
3 curacy of the provider directory
4 information every 30 days.

5 “(gg) Other factors as deter-
6 mined by the Secretary.

7 “(iii) REQUIREMENTS OF THE INDE-
8 PENDENT AUDIT.—An audit under this
9 subparagraph is complete if all of the fol-
10 lowing conditions are met:

11 “(I) The audit report includes
12 the following:

13 “(aa) A statement by the
14 independent auditor that, to the
15 best of the auditor’s knowledge,
16 the report is complete and accu-
17 rate, and that reasonable as-
18 sumptions related to statistics
19 and research methods have been
20 complied with.

21 “(bb) A statement explain-
22 ing the assumptions, statistics,
23 and methods used to select the
24 sample and assess provider direc-
25 tory information accuracy.

1 “(cc) Such other informa-
2 tion as the Secretary determines
3 necessary.

4 “(II) The group health plan or
5 health insurer issuer makes the inde-
6 pendent audit available on a public
7 website.

8 “(iv) RULEMAKING.—The Secretary,
9 the Secretary of Labor, and the Secretary
10 of the Treasury shall issue interim final
11 regulations (without prior notice and com-
12 ment as required under section 553 of title
13 5, United States Code) concerning the na-
14 tional standards for conducting audits
15 under this subparagraph, not later than 2
16 years after the date of enactment of the
17 Behavioral Health Network and Directory
18 Improvement Act.

19 “(C) AUDITS BY THE SECRETARY.—

20 “(i) IN GENERAL.—Beginning not
21 later than the third plan year after the
22 date of enactment of the Behavioral
23 Health Network and Directory Improve-
24 ment Act, the Secretary shall conduct an-
25 nual audits to ensure compliance with the

1 provider directory requirements of this
2 subsection.

3 “(ii) REQUIREMENTS.—Audits con-
4 ducted by the Secretary under this sub-
5 paragraph shall—

6 “(I) assess the accuracy of the
7 information provided in health plan
8 directories required under this sub-
9 section, including the proportion of
10 listings with incorrect information, the
11 last date on which the behavioral
12 health network of the group health
13 plan or health insurance coverage was
14 updated, and other information deter-
15 mined appropriate by the Secretary;
16 and

17 “(II) use reasonable assumptions
18 related to statistics and research
19 methods to identify a representative
20 sample of listings for analysis and
21 such methods as the Secretary deter-
22 mines appropriate, which may include
23 retrospective analysis of billing data.

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

1 nual audits of a total of not fewer than 10
 2 group health plans or health insurance
 3 issuers offering group or individual health
 4 insurance coverage, as determined by the
 5 Secretary, that are the subjects of com-
 6 plaints about ghost networks or other com-
 7 plaints, or that are randomly selected by
 8 the Secretary.”; and

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

10 (i) in the paragraph heading, by strik-
 11 ing “DEFINITION” and inserting “DEFINI-
 12 TIONS”;

13 (ii) by striking “For purposes of this
 14 subsection, the term” and inserting the fol-
 15 lowing: “For purposes of this subsection:

16 “(A) PROVIDER DIRECTORY INFORMA-
 17 TION.—The term”;

18 (iii) by striking “health insurance cov-
 19 erage, the name” and inserting “health in-
 20 surance coverage—

21 “(i) the name”;

22 (iv) by striking the period and insert-
 23 ing “; and”; and

24 (v) by adding at the end the following:

1 “(ii) with respect to each such pro-
 2 vider or facility—

3 “(I) whether such provider or fa-
 4 cility is accepting new patients;

5 “(II) the languages spoken and
 6 the availability of language translators
 7 for specified languages at each health
 8 care facility listed in the directory;

9 “(III) whether the provider or fa-
 10 cility offers medication-assisted treat-
 11 ment for opioid use disorder;

12 “(IV) the State license number;

13 “(V) the national provider identi-
 14 fier;

15 “(VI) the age groups served by
 16 the provider or facility, such as pedi-
 17 atric, adolescent, adult, or geriatric
 18 populations;

19 “(VII) whether such provider or
 20 facility offers in-person services, tele-
 21 health services, or both; and

22 “(VIII) the cost-sharing tier, if
 23 applicable.

24 “(B) GHOST NETWORK.—The term ‘ghost
 25 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 re-
quired 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 Sec-
retary of Labor and the Secretary of the
Treasury) in a specialty who are not ac-
cepting 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, bene-
ficiary, or enrollee and item or service”; and

(B) by striking paragraph (2) and insert-
ing the following:

1 “(2) RECONCILIATION REQUIREMENT.—For
 2 purposes of paragraph (1), a group health plan or
 3 group or individual health insurance coverage of-
 4 fered by a health insurance issuer, on a regular
 5 basis, shall reconcile payment requests for items or
 6 services furnished by a nonparticipating provider or
 7 a nonparticipating facility and the posted provider
 8 directory database for the day the delivered item or
 9 service was provided. If a nonparticipating provider
 10 was listed as a participating provider in the direc-
 11 tory, the group health plan or health insurance
 12 issuer shall notify the participant, beneficiary, or en-
 13 rollee, in plain language, that the participant, bene-
 14 ficiary, or enrollee may be eligible for a refund from
 15 the group health plan or health insurance issuer if
 16 such participant, beneficiary, or enrollee paid the out
 17 of network cost-sharing and did not receive a refund
 18 under section 2799B–9(b).”.

19 (b) ERISA.—

20 (1) IN GENERAL.—Section 720 of the Employee
 21 Retirement Income Security Act of 1974 (29 U.S.C.
 22 1185i) is amended—

23 (A) in subsection (a)—

24 (i) in paragraph (1)—

1 (I) by striking “For plan years
2 beginning on or after January 1,
3 2022, each” and inserting “Each”;

4 (II) in subparagraph (C), by
5 striking “; and” and inserting a semi-
6 colon;

7 (III) in subparagraph (D), by
8 striking the period and inserting “;
9 and”; and

10 (IV) by adding at the end the fol-
11 lowing:

12 “(E) ensure that any directory, including
13 the database described in subparagraph (C),
14 containing provider directory information with
15 respect to such plan or such coverage complies
16 with the requirements developed by the appro-
17 priate agencies in accordance with paragraph
18 (6) in order to ensure that participants, bene-
19 ficiaries, and enrollees are able to identify ac-
20 tively participating health care providers and
21 health care facilities.”;

22 (ii) in paragraph (2)(A), by striking
23 “90 days” and inserting “30 days”;

24 (iii) in paragraph (3)—

1 (I) in the matter preceding sub-
2 paragraph (A), by striking “, in the
3 case such request is made through a
4 telephone call”; and

5 (II) in subparagraph (A), by
6 striking “call is received, through a
7 written electronic or print (as re-
8 quested by such individual) commu-
9 nication” and inserting “a request is
10 received, by telephone, or through a
11 written electronic or print communica-
12 tion (as requested by such indi-
13 vidual)”;

14 (iv) in paragraph (4)—

15 (I) in subparagraph (A), by strik-
16 ing “and” at the end;

17 (II) in subparagraph (B), by
18 striking the period and inserting “;
19 and”; and

20 (III) by adding at the end the
21 following:

22 “(C) information, in plain language, con-
23 cerning the rights of the participant, bene-
24 ficiary, or enrollee to cost-sharing protections
25 pursuant to subsection (b) in the event of reli-

1 ance on inaccurate provider network informa-
 2 tion supplied by a group health plan or health
 3 insurance issuer, and contact information for
 4 the State consumer assistance program or om-
 5 budsman for more information.”;

6 (v) in paragraph (5), by adding at the
 7 end the following: “Such information shall
 8 include a statement, in plain language,
 9 concerning the rights of the participant,
 10 beneficiary, or enrollee to cost-sharing pro-
 11 tections pursuant to subsection (b) in the
 12 event of reliance on inaccurate provider di-
 13 rectory information supplied by a group
 14 health plan or health insurance issuer, and
 15 contact information for the State consumer
 16 assistance program or ombudsman for
 17 more information.”;

18 (vi) by redesignating paragraphs (6)
 19 and (7) as paragraphs (8) and (9), respec-
 20 tively;

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

23 “(6) PROTECTING PARTICIPANTS, BENE-
 24 FICIARIES, AND ENROLLEES FROM GHOST NET-
 25 WORKS.—The Secretary, in collaboration with the

1 Secretary of Labor and the Secretary of the Treas-
2 ury, shall—

3 “(A) not later than 180 days after the date
4 of enactment of the Behavioral Health Network
5 and Directory Improvement Act, issue interim
6 final regulations (without prior notice and com-
7 ment as required under section 553 of title 5,
8 United States Code) further defining the term
9 ‘ghost network’ (as defined in paragraph (8));
10 and

11 “(B) not later than 18 months after the
12 date of enactment of the Behavioral Health
13 Network and Directory Improvement Act, issue
14 interim final regulations (without prior notice
15 and comment as required under section 553 of
16 title 5, United States Code), subregulatory
17 guidance, or program instruction on how to as-
18 sess ghost networks in health plan directories
19 including reasonable assumptions related to sta-
20 tistics and research methods.

21 “(7) DATABASE REPORTING AND AUDITING TO
22 PROTECT AGAINST GHOST NETWORKS.—

23 “(A) REPORTING REQUIREMENTS.—Begin-
24 ning not later than 3 years after the date of en-
25 actment of the Behavioral Health Network and

1 Directory Improvement Act, each group health
2 plan and health insurance issuer offering group
3 health insurance coverage shall submit to the
4 Secretary, at such time as the Secretary, in co-
5 ordination with the Secretary of Health and
6 Human Services and the Secretary of the
7 Treasury, shall require, but not less frequently
8 than annually, the directory data described in
9 paragraph (a)(4), in a machine readable format
10 (as defined in section 147.210(a)(2)(xiv) of title
11 45, Code of Federal Regulations (or any suc-
12 cessor regulations)). The Secretary, in coordina-
13 tion with the Secretary of Health and Human
14 Services and the Secretary of the Treasury,
15 shall make data submitted under this subpara-
16 graph available on a public website.

17 “(B) PROVIDER DIRECTORY INDEPENDENT
18 AUDIT REQUIREMENTS.—

19 “(i) IN GENERAL.—Beginning not
20 later than 3 years after the date of enact-
21 ment of the Behavioral Health Network
22 and Directory Improvement Act, each
23 group health plan and health insurance
24 issuer offering group health insurance cov-
25 erage shall conduct an annual directory

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

6 “(ii) FACTORS.—

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

10 “(aa) develop a list of fac-
 11 tors to be considered; and

12 “(bb) provide guidelines for
 13 carrying out such audits, for use
 14 by group health plans and health
 15 insurance issuers, on—

16 “(AA) the reasonable
 17 assumptions and research
 18 methods to select a reason-
 19 able sample in order to as-
 20 sess provider directory infor-
 21 mation accuracy; and

22 “(BB) determining the
 23 criteria of an eligible audi-
 24 tor.

1 “(II) CONTENTS.—The factors
2 under subclause (I)(aa) shall include
3 the following:

4 “(aa) A list of every health
5 care provider and health care fa-
6 cility that was part of the net-
7 work of the applicable plan or
8 coverage, the months during the
9 plan year during which each such
10 provider or facility was part of
11 the network, and the number of
12 participants, beneficiaries, and
13 enrollees in the plan or coverage
14 (including participants, bene-
15 ficiaries, and enrollees who are
16 new patients of the provider)
17 each such provider or facility
18 treated during such period.

19 “(bb) The proportion of di-
20 rectory listings of the plan or
21 coverage with inaccurate infor-
22 mation, including incorrect con-
23 tact information, including incor-
24 rect contact information, as spec-

1 ified by the Secretary, during the
2 audit period.

3 “(cc) The number of in-net-
4 work items or services paid on
5 behalf of participants, bene-
6 ficiaries, and enrollees in the plan
7 or coverage to providers or facili-
8 ties who have a network provider
9 contract with the health plan or
10 issuer and were not listed in the
11 directory of the health plan or
12 health insurance coverage for the
13 audit period.

14 “(dd) The resources of the
15 plan or issuer to help partici-
16 pants, beneficiaries, and enrollees
17 locate an accurately listed in-net-
18 work provider who is accepting
19 new patients.

20 “(ee) The proportion of par-
21 ticipants, beneficiaries, and en-
22 rollees using out-of-network pro-
23 viders for mental health and sub-
24 stance use disorder services, and
25 the proportion of participants,

1 beneficiaries, and enrollees using
2 out-of-network providers and fa-
3 cilities for medical and surgical
4 services.

5 “(ff) Documentation that
6 the plan or issuer verifies the ac-
7 curacy of the provider directory
8 information every 30 days.

9 “(gg) Other factors as deter-
10 mined by the Secretary.

11 “(iii) REQUIREMENTS OF THE INDE-
12 PENDENT AUDIT.—An audit under this
13 subparagraph is complete if all of the fol-
14 lowing conditions are met:

15 “(I) The audit report includes
16 the following:

17 “(aa) A statement by the
18 independent auditor that, to the
19 best of the auditor’s knowledge,
20 the report is complete and accu-
21 rate, and that reasonable as-
22 sumptions related to statistics
23 and research methods have been
24 complied with.

1 “(bb) A statement explain-
2 ing the assumptions, statistics,
3 and methods used to select the
4 sample and assess provider direc-
5 tory information accuracy.

6 “(cc) Such other informa-
7 tion as the Secretary determines
8 necessary.

9 “(II) The group health plan or
10 health insurer issuer makes the inde-
11 pendent audit available on a public
12 website.

13 “(iv) RULEMAKING.—The Secretary,
14 the Secretary of Health and Human Serv-
15 ices, and the Secretary of the Treasury
16 shall issue interim final regulations (with-
17 out prior notice and comment as required
18 under section 553 of title 5, United States
19 Code) concerning the national standards
20 for conducting audits under this subpara-
21 graph, not later than 2 years after the
22 date of enactment of the Behavioral
23 Health Network and Directory Improve-
24 ment Act.

25 “(C) AUDITS BY THE SECRETARY.—

1 “(i) IN GENERAL.—Beginning not
2 later than the third plan year after the
3 date of enactment of the Behavioral
4 Health Network and Directory Improve-
5 ment Act, the Secretary shall conduct an-
6 nual audits to ensure compliance with the
7 provider directory requirements of this
8 subsection.

9 “(ii) REQUIREMENTS.—Audits con-
10 ducted by the Secretary under this sub-
11 paragraph shall—

12 “(I) assess the accuracy of the
13 information provided in health plan
14 directories required under this sub-
15 section, including the proportion of
16 listings with incorrect information, the
17 last date on which the behavioral
18 health network of the group health
19 plan or health insurance coverage was
20 updated, and other information deter-
21 mined appropriate by the Secretary;
22 and

23 “(II) use reasonable assumptions
24 related to statistics and research
25 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”;

1 (III) by striking “health insur-
2 ance coverage, the name” and insert-
3 ing “health insurance coverage—
4 “(i) the name”;

5 (IV) by striking the period and
6 inserting “; and”; and

7 (V) by adding at the end the fol-
8 lowing:

9 “(ii) with respect to each such pro-
10 vider or facility—

11 “(I) whether such provider or fa-
12 cility is accepting new patients;

13 “(II) the languages spoken and
14 the availability of language translators
15 for specified languages at each health
16 care facility listed in the directory;

17 “(III) whether the provider or fa-
18 cility offers medication-assisted treat-
19 ment for opioid use disorder;

20 “(IV) the State license number;

21 “(V) the national provider identi-
22 fier;

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

1 atric, adolescent, adult, or geriatric
2 populations;

3 “(VII) whether such provider or
4 facility offers in-person services, tele-
5 health services, or both; and

6 “(VIII) the cost-sharing tier, if
7 applicable.

8 “(B) GHOST NETWORK.—The term ‘ghost
9 network’ means a group health plan or group
10 health insurance coverage for which the pro-
11 vider directory information describing the net-
12 work of such plan or coverage—

13 “(i) does not include accurate re-
14 quired information for purposes of making
15 an appointment for in-network care within
16 a reasonable time period;

17 “(ii) includes a meaningful number of
18 providers and facilities (as specified by the
19 Secretary, in coordination with the Sec-
20 retary of Health and Human Services and
21 the Secretary of the Treasury) in a spe-
22 cialty who are not accepting new patients
23 within a time period specified by such sec-
24 retaries;

1 “(iii) includes providers that are not
2 part of the network; or

3 “(iv) omits providers that are part of
4 the network.”; and

5 (B) in subsection (b)—

6 (i) in paragraph (1), by striking “and
7 if either of the criteria described in para-
8 graph (2) applies with respect to such par-
9 ticipant, beneficiary, or enrollee and item
10 or service”; and

11 (ii) by striking paragraph (2) and in-
12 serting the following:

13 “(2) RECONCILIATION REQUIREMENT.—For
14 purposes of paragraph (1), a group health plan or
15 group health insurance coverage offered by a health
16 insurance issuer, on a regular basis, shall reconcile
17 payment requests for items or services furnished by
18 a nonparticipating provider or a nonparticipating fa-
19 cility and the posted provider directory database for
20 the day the delivered item or service was provided.
21 If a nonparticipating provider was listed as a partici-
22 pating provider in the directory, the group health
23 plan or health insurance issuer shall notify the par-
24 ticipant, beneficiary, or enrollee, in plain language,
25 that the participant, beneficiary, or enrollee may be

1 eligible for a refund from the group health plan or
 2 health insurance issuer if such participant, bene-
 3 ficiary, or enrollee paid the out of network cost-shar-
 4 ing and did not receive a refund under section
 5 2799B–9(b) of the Public Health Service Act (42
 6 U.S.C. 300gg–139).”.

7 (2) CIVIL MONETARY PENALTIES FOR VIOLA-
 8 TIONS.—

9 (A) CIVIL MONETARY PENALTIES RELAT-
 10 ING TO PROVIDER DIRECTORY REQUIRE-
 11 MENTS.—Section 502(c)(10) of the Employee
 12 Retirement Income Security Act of 1974 (29
 13 U.S.C. 1132(c)(10)(A)) is amended—

14 (i) in the heading, by striking “USE
 15 OF GENETIC INFORMATION” and inserting
 16 “USE OF GENETIC INFORMATION AND PRO-
 17 VIDER DIRECTORY REQUIREMENTS”; and

18 (ii) in subparagraph (A)—

19 (I) by striking “any plan sponsor
 20 of a group health plan” and inserting
 21 “any plan sponsor or plan adminis-
 22 trator of a group health plan”; and

23 (II) by striking “for any failure”
 24 and all that follows through “in con-
 25 nection with the plan.” and inserting

1 “for any failure by such plan sponsor,
 2 plan administrator, or health insur-
 3 ance issuer, in connection with the
 4 plan—

5 “(i) to meet the requirements of sub-
 6 section (a)(1)(F), (b)(3), (c), or (d) of sec-
 7 tion 702 or section 701 or 702(b)(1) with
 8 respect to genetic information; or

9 “(ii) to meet the requirements of sec-
 10 tion 720 with respect to provider directory
 11 information.”.

12 (B) EXCEPTION TO THE GENERAL PROHI-
 13 BITION ON ENFORCEMENT.—Section 502 of
 14 such Act (29 U.S.C. 1132) is amended—

15 (i) in subsection (a)(6), by striking
 16 “or (9)” and inserting “(9), or (10)”; and
 17 (ii) in subsection (b)(3)—

18 (I) by striking “subsections
 19 (c)(9) and (a)(6)” and inserting “sub-
 20 sections (c)(9), (c)(10), and (a)(6)”; and

21 (II) by striking “under sub-
 22 section (c)(9))” and inserting “under
 23 subsections (c)(9) and (c)(10)), and
 24 except with respect to enforcement by
 25 the Secretary of section 720”; and

1 (III) by striking “706(a)(1)” and
 2 inserting “733(a)(1)”.

3 (C) EFFECTIVE DATE.—The amendments
 4 made by subparagraph (A) shall apply with re-
 5 spect to group health plans, or any health in-
 6 surance issuer offering health insurance cov-
 7 erage in connection with such plan, for plan
 8 years beginning after the date that is 1 year
 9 after the date of enactment of this Act.

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

12 (1) in subsection (a)—

13 (A) in paragraph (1)—

14 (i) by striking “For plan years begin-
 15 ning on or after January 1, 2022, each”
 16 and inserting “Each”;

17 (ii) in subparagraph (C), by striking
 18 “; and” and inserting a semicolon;

19 (iii) in subparagraph (D), by striking
 20 the period and inserting “; and”; and

21 (iv) by adding at the end the fol-
 22 lowing:

23 “(E) ensure that any directory, including
 24 the database described in subparagraph (C),
 25 containing provider directory information with

1 respect to such plan complies with the require-
2 ments developed by the appropriate agencies in
3 accordance with paragraph (6) in order to en-
4 sure that participants, beneficiaries, and enroll-
5 ees are able to identify actively participating
6 health care providers and health care facili-
7 ties.”;

8 (B) in paragraph (2)(A), by striking “90
9 days” and inserting “30 days”;

10 (C) in paragraph (3)—

11 (i) in the matter preceding subpara-
12 graph (A), by striking “, in the case such
13 request is made through a telephone call”;
14 and

15 (ii) in subparagraph (A), by striking
16 “call is received, through a written elec-
17 tronic or print (as requested by such indi-
18 vidual) communication” and inserting “a
19 request is received, by telephone, or
20 through a written electronic or print com-
21 munication (as requested by such indi-
22 vidual)”;

23 (D) in paragraph (4)—

24 (i) in subparagraph (A), by striking
25 “and” at the end;

1 (ii) in subparagraph (B), by striking
2 the period and inserting “; and”; and

3 (iii) by adding at the end the fol-
4 lowing:

5 “(C) information, in plain language, con-
6 cerning the rights of the participant, bene-
7 ficiary, or enrollee to cost-sharing protections
8 pursuant to subsection (b) in the event of reli-
9 ance on inaccurate provider network informa-
10 tion supplied by a group health plan, and con-
11 tact information for the State consumer assist-
12 ance program or ombudsman for more informa-
13 tion.”;

14 (E) in paragraph (5), by adding at the end
15 the following: “Such information shall include a
16 statement, in plain language, concerning the
17 rights of the participant, beneficiary, or enrollee
18 to cost-sharing protections pursuant to sub-
19 section (b) in the event of reliance on inac-
20 curate provider directory information supplied
21 by a group health plan, and contact information
22 for the State consumer assistance program or
23 ombudsman for more information.”;

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

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

3 “(6) PROTECTING PARTICIPANTS, BENE-
4 FICIARIES, AND ENROLLEES FROM GHOST NET-
5 WORKS.—The Secretary, in collaboration with the
6 Secretary of Labor and the Secretary of Health and
7 Human Services, shall—

8 “(A) not later than 180 days after the date
9 of enactment of the Behavioral Health Network
10 and Directory Improvement Act, issue interim
11 final regulations (without prior notice and com-
12 ment as required under section 553 of title 5,
13 United States Code) further defining the term
14 ‘ghost network’ (as defined in paragraph (8));
15 and

16 “(B) not later than 18 months after the
17 date of enactment of the Behavioral Health
18 Network and Directory Improvement Act, issue
19 interim final regulations (without prior notice
20 and comment as required under section 553 of
21 title 5, United States Code), subregulatory
22 guidance, or program instruction on how to as-
23 sess ghost networks in health plan directories
24 including reasonable assumptions related to sta-
25 tistics and research methods.

1 “(7) DATABASE REPORTING AND AUDITING TO
2 PROTECT AGAINST GHOST NETWORKS.—

3 “(A) REPORTING REQUIREMENTS.—Begin-
4 ning not later than 3 years after the date of en-
5 actment of the Behavioral Health Network and
6 Directory Improvement Act, each group health
7 plan shall submit to the Secretary, at such time
8 as the Secretary, in coordination with the Sec-
9 retary of Labor and the Secretary of Health
10 and Human Services, shall require, but not less
11 frequently than annually, the directory data de-
12 scribed in paragraph (a)(4), in a machine read-
13 able format (as defined in section
14 147.210(a)(2)(xiv) of title 45, Code of Federal
15 Regulations (or any successor regulations)).
16 The Secretary, in coordination with the Sec-
17 retary of Labor and the Secretary of Health
18 and Human Services, shall make data sub-
19 mitted under this subparagraph available on a
20 public website.

21 “(B) PROVIDER DIRECTORY INDEPENDENT
22 AUDIT REQUIREMENTS.—

23 “(i) IN GENERAL.—Beginning not
24 later than 3 years after the date of enact-
25 ment of the Behavioral Health Network

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

8 “(ii) FACTORS.—

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

12 “(aa) develop a list of fac-
 13 tors to be considered; and

14 “(bb) provide guidelines for
 15 carrying out such audits, for use
 16 by group health plans, on—

17 “(AA) the reasonable
 18 assumptions and research
 19 methods to select a reason-
 20 able sample in order to as-
 21 sess provider directory infor-
 22 mation accuracy; and

23 “(BB) determining the
 24 criteria of an eligible audi-
 25 tor.

1 “(II) CONTENTS.—The factors
2 under subclause (I)(aa) shall include
3 the following:

4 “(aa) A list of every health
5 care provider and health care fa-
6 cility that was part of the net-
7 work of the applicable plan, the
8 months during the plan year dur-
9 ing which each such provider or
10 facility was part of the network,
11 and the number of participants,
12 beneficiaries, and enrollees in the
13 plan (including participants,
14 beneficiaries, and enrollees who
15 are new patients of the provider)
16 each such provider or facility
17 treated during such period.

18 “(bb) The proportion of di-
19 rectory listings of the plan with
20 inaccurate information, including
21 incorrect contact information, in-
22 cluding incorrect contact infor-
23 mation, as specified by the Sec-
24 retary, during the audit period.

1 “(cc) The number of in-net-
2 work items or services paid on
3 behalf of participants, bene-
4 ficiaries, and enrollees in the plan
5 to providers or facilities who have
6 a network provider contract with
7 the health plan and were not list-
8 ed in the directory of the health
9 plan for the audit period.

10 “(dd) The resources of the
11 plan to help participants, bene-
12 ficiaries, and enrollees locate an
13 accurately listed in-network pro-
14 vider who is accepting new pa-
15 tients.

16 “(ee) The proportion of par-
17 ticipants, beneficiaries, and en-
18 rollees using out-of-network pro-
19 viders for mental health and sub-
20 stance use disorder services, and
21 the proportion of participants,
22 beneficiaries, and enrollees using
23 out-of-network providers and fa-
24 cilities for medical and surgical
25 services.

1 “(ff) Documentation that
2 the plan verifies the accuracy of
3 the provider directory informa-
4 tion every 30 days.

5 “(gg) Other factors as deter-
6 mined by the Secretary.

7 “(iii) REQUIREMENTS OF THE INDE-
8 PENDENT AUDIT.—An audit under this
9 subparagraph is complete if all of the fol-
10 lowing conditions are met:

11 “(I) The audit report includes
12 the following:

13 “(aa) A statement by the
14 independent auditor that, to the
15 best of the auditor’s knowledge,
16 the report is complete and accu-
17 rate, and that reasonable as-
18 sumptions related to statistics
19 and research methods have been
20 complied with.

21 “(bb) A statement explain-
22 ing the assumptions, statistics,
23 and methods used to select the
24 sample and assess provider direc-
25 tory information accuracy.

1 “(cc) Such other informa-
2 tion as the Secretary determines
3 necessary.

4 “(II) The group health plan
5 makes the independent audit available
6 on a public website.

7 “(iv) RULEMAKING.—The Secretary,
8 the Secretary of Labor, and the Secretary
9 of Health and Human Services shall issue
10 interim final regulations (without prior no-
11 tice and comment as required under sec-
12 tion 553 of title 5, United States Code)
13 concerning the national standards for con-
14 ducting audits under this subparagraph,
15 not later than 2 years after the date of en-
16 actment of the Behavioral Health Network
17 and Directory Improvement Act.

18 “(C) AUDITS BY THE SECRETARY.—

19 “(i) IN GENERAL.—Beginning not
20 later than the third plan year after the
21 date of enactment of the Behavioral
22 Health Network and Directory Improve-
23 ment Act, the Secretary shall conduct an-
24 nual audits to ensure compliance with the

1 provider directory requirements of this
2 subsection.

3 “(ii) REQUIREMENTS.—Audits con-
4 ducted by the Secretary under this sub-
5 paragraph shall—

6 “(I) assess the accuracy of the
7 information provided in health plan
8 directories required under this sub-
9 section, including the proportion of
10 listings with incorrect information, the
11 last date on which the behavioral
12 health network of the group health
13 plan was updated, and other informa-
14 tion determined appropriate by the
15 Secretary; and

16 “(II) use reasonable assumptions
17 related to statistics and research
18 methods to identify a representative
19 sample of listings for analysis and
20 such methods as the Secretary deter-
21 mines appropriate, which may include
22 retrospective analysis of billing data.

23 “(iii) SELECTION OF PLANS.—The
24 Secretary shall conduct annual audits of a
25 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 “DEFINI-
 TIONS”;

(ii) by striking “For purposes of this
 subsection, the term” and inserting the fol-
 lowing: “For purposes of this subsection:

“(A) PROVIDER DIRECTORY INFORMA-
 TION.—The term”;

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

“(i) the name”;

(iv) by striking the period and insert-
 ing “; and”; and

(v) by adding at the end the following:

“(ii) with respect to each such pro-
 vider or facility—

“(I) whether such provider or fa-
 cility is accepting new patients;

1 “(II) the languages spoken and
 2 the availability of language translators
 3 for specified languages at each health
 4 care facility listed in the directory;

5 “(III) whether the provider or fa-
 6 cility offers medication-assisted treat-
 7 ment for opioid use disorder;

8 “(IV) the State license number;

9 “(V) the national provider identi-
 10 fier;

11 “(VI) the age groups served by
 12 the provider or facility, such as pedi-
 13 atric, adolescent, adult, or geriatric
 14 populations;

15 “(VII) whether such provider or
 16 facility offers in-person services, tele-
 17 health services, or both; and

18 “(VIII) the cost-sharing tier, if
 19 applicable.

20 “(B) GHOST NETWORK.—The term ‘ghost
 21 network’ means a group health plan for which
 22 the provider directory information describing
 23 the network of such plan—

24 “(i) does not include accurate re-
 25 quired information for purposes of making

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

3 “(ii) includes a meaningful number of
 4 providers and facilities (as specified by the
 5 Secretary, in coordination with the Sec-
 6 retary of Labor and the Secretary of
 7 Health and Human Services) in a specialty
 8 who are not accepting new patients within
 9 a time period specified by such secretaries;

10 “(iii) includes providers that are not
 11 part of the network; or

12 “(iv) omits providers that are part of
 13 the network.”; and

14 (2) in subsection (b)—

15 (A) in paragraph (1), by striking “and if
 16 either of the criteria described in paragraph (2)
 17 applies with respect to such participant, bene-
 18 ficiary, or enrollee and item or service”; and

19 (B) by striking paragraph (2) and insert-
 20 ing the following:

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

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

12 **SEC. 3. PROVIDER REQUIREMENTS TO PROTECT PATIENTS**
 13 **AND IMPROVE THE ACCURACY OF PROVIDER**
 14 **DIRECTORY INFORMATION.**

15 Section 2799B–9 of the Public Health Service Act
 16 (42 U.S.C. 300gg–139) is amended—

17 (1) in subsection (a)—

18 (A) in paragraph (3), by striking “; and”
 19 and inserting a semicolon;

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

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

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

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

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

7 (2) by amending subsection (d) to read as fol-
 8 lows:

9 “(d) DEFINITION.—For purposes of this section, the
 10 term ‘provider directory information’ includes—

11 “(1) the name, address, specialty, telephone
 12 number, and digital contact information of each in-
 13 dividual health care provider contracted to partici-
 14 pate in any of the networks of the group health plan
 15 or health insurance coverage involved;

16 “(2) the name, address, specialty, telephone
 17 number, and digital contact information of each
 18 medical group, clinic, or facility contracted to par-
 19 ticipate in any of the networks of the group health
 20 plan or health insurance coverage involved; and

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

23 “(A) whether such provider, medical group,
 24 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.—

1 “(A) IN GENERAL.—The Secretary, the
2 Secretary of Labor, and the Secretary of the
3 Treasury shall issue regulations establishing na-
4 tional quantitative standards for mental health
5 and substance use disorder network adequacy.
6 Such standards shall consider—

7 “(i) the ratio of in-network mental
8 health providers, separated by professional
9 type of mental health provider, to partici-
10 pants, beneficiaries, and enrollees in a
11 group health plan or health insurance cov-
12 erage;

13 “(ii) the ratio of in-network substance
14 use disorder providers, separated by pro-
15 fessional type of substance use disorder
16 provider, to participants, beneficiaries, and
17 enrollees in a group health plan or health
18 insurance coverage;

19 “(iii) separately, for each of mental
20 health services and substance use disorder
21 services—

22 “(I) geographic accessibility of
23 providers;

24 “(II) geographic variation and
25 population dispersion;

1 “(III) waiting times for appoint-
2 ments with participating providers;

3 “(IV) hours of operation for par-
4 ticipating providers;

5 “(V) the ability of the network to
6 meet the needs of participants, bene-
7 ficiaries, and enrollees, including low-
8 income individuals, individuals who
9 are members of a racial or ethnic mi-
10 nority, individuals who live in a health
11 professional shortage area, children
12 and adults with serious, chronic, and
13 complex health conditions, individuals
14 with physical or mental disabilities or
15 substance use disorders, pediatric
16 populations, and individuals with lim-
17 ited English proficiency;

18 “(VI) the availability of in-person
19 services, telehealth services, and hy-
20 brid services to serve the needs of par-
21 ticipants, beneficiaries, and enrollees;
22 and

23 “(VII) the percentage of in-net-
24 work providers who have submitted a

1 claim for payment during the previous
2 6 months; and

3 “(iv) other standards as determined
4 by the Secretary, the Secretary of Labor,
5 and the Secretary of the Treasury.

6 “(B) TIMING.—

7 “(i) ISSUANCE.—The Secretary, the
8 Secretary of Labor, and the Secretary of
9 the Treasury shall—

10 “(I) issue proposed regulations
11 required under subparagraph (A) not
12 later than 2 years after the date of
13 enactment of the Behavioral Health
14 Network and Directory Improvement
15 Act; and

16 “(II) issue final regulations
17 under subparagraph (A) not later
18 than 1 year thereafter.

19 “(ii) EFFECTIVE DATE.—The regula-
20 tions promulgated under this paragraph
21 shall take effect in the first plan year that
22 begins after the date on which such final
23 regulations are issued.

24 “(C) AUDITS.—The Secretary, the Sec-
25 retary of Labor, and the Secretary of the

1 Treasury shall conduct annual, targeted audits
 2 of not fewer than 10 group health plans and
 3 health insurance issuers offering group or indi-
 4 vidual health insurance coverage that the Secre-
 5 taries determine to be the subject of the great-
 6 est number of complaints about mental health
 7 and substance use disorder network adequacy
 8 to ensure compliance with the requirements of
 9 this paragraph. Such audits shall begin not ear-
 10 lier than one year after the final regulations im-
 11 plementing this paragraph begin to apply to
 12 group health plans and health insurance
 13 issuers.”.

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

18 “(4) MENTAL HEALTH BENEFITS.—The term
 19 ‘mental health benefits’ means benefits with respect
 20 to services related to a mental health condition, de-
 21 fined consistently with generally recognized inde-
 22 pendent standards of current medical practice, such
 23 as the Diagnostic and Statistical Manual of Mental
 24 Disorders of the American Psychiatric Association.

1 “(5) SUBSTANCE USE DISORDER BENEFITS.—
 2 The term ‘substance use disorder benefits’ means
 3 benefits with respect to services related to a sub-
 4 stance use disorder, defined consistently with gen-
 5 erally recognized independent standards of current
 6 medical practice, such as the Diagnostic and Statis-
 7 tical Manual of Mental Disorders of the American
 8 Psychiatric Association.”.

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

14 “(10) STANDARDS FOR PARITY IN REIMBURSE-
 15 MENT RATES.—

16 “(A) IN GENERAL.—Not later than 2 years
 17 after the date of enactment of the Behavioral
 18 Health Network and Directory Improvement
 19 Act, the Secretary, the Secretary of Labor, and
 20 the Secretary of the Treasury shall issue regu-
 21 lations on a standard for parity in reimburse-
 22 ment rates for mental health or substance use
 23 disorder benefits and medical and surgical bene-
 24 fits, based on a comparative analysis conducted
 25 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

1 the Secretary of the Treasury shall issue regu-
2 lations establishing national quantitative stand-
3 ards for mental health and substance use dis-
4 order network adequacy. Such standards shall
5 consider—

6 “(i) the ratio of in-network mental
7 health providers, separated by professional
8 type of mental health provider, to partici-
9 pants, beneficiaries, and enrollees in a
10 group health plan or health insurance cov-
11 erage;

12 “(ii) the ratio of in-network substance
13 use disorder providers, separated by pro-
14 fessional type of substance use disorder
15 provider, to participants, beneficiaries, and
16 enrollees in a group health plan or health
17 insurance coverage;

18 “(iii) separately, for each of mental
19 health services and substance use disorder
20 services—

21 “(I) geographic accessibility of
22 providers;

23 “(II) geographic variation and
24 population dispersion;

1 “(III) waiting times for appoint-
2 ments with participating providers;

3 “(IV) hours of operation for par-
4 ticipating providers;

5 “(V) the ability of the network to
6 meet the needs of participants, bene-
7 ficiaries, and enrollees, including low-
8 income individuals, individuals who
9 are members of a racial or ethnic mi-
10 nority, individuals who live in a health
11 professional shortage area, children
12 and adults with serious, chronic, and
13 complex health conditions, individuals
14 with physical or mental disabilities or
15 substance use disorders, pediatric
16 populations, and individuals with lim-
17 ited English proficiency;

18 “(VI) the availability of in-person
19 services, telehealth services, and hy-
20 brid services to serve the needs of par-
21 ticipants, beneficiaries, and enrollees;
22 and

23 “(VII) the percentage of in-net-
24 work providers who have submitted a

1 claim for payment during the previous
2 6 months; and

3 “(iv) other standards as determined
4 by the Secretary, the Secretary of Health
5 and Human Services, and the Secretary of
6 the Treasury.

7 “(B) TIMING.—

8 “(i) ISSUANCE.—The Secretary, the
9 Secretary of Health and Human Services,
10 and the Secretary of the Treasury shall—

11 “(I) issue proposed regulations
12 required under subparagraph (A) not
13 later than 2 years after the date of
14 enactment of the Behavioral Health
15 Network and Directory Improvement
16 Act; and

17 “(II) issue final regulations
18 under subparagraph (A) not later
19 than 1 year thereafter.

20 “(ii) EFFECTIVE DATE.—The regula-
21 tions promulgated under this paragraph
22 shall take effect in the first plan year that
23 begins after the date on which such final
24 regulations are issued.

1 “(C) AUDITS.—The Secretary, the Sec-
 2 retary of Health and Human Services, and the
 3 Secretary of the Treasury shall conduct annual,
 4 targeted audits of not fewer than 10 group
 5 health plans and health insurance issuers offer-
 6 ing group health insurance coverage that the
 7 Secretaries determine to be the subject of the
 8 greatest number of complaints about mental
 9 health and substance use disorder network ade-
 10 quacy to ensure compliance with the require-
 11 ments of this paragraph. Such audits shall
 12 begin not earlier than one year after the final
 13 regulations implementing this paragraph begin
 14 to apply to group health plans and health insur-
 15 ance issuers.”.

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

20 “(4) MENTAL HEALTH BENEFITS.—The term
 21 ‘mental health benefits’ means benefits with respect
 22 to services related to a mental health condition, de-
 23 fined consistently with generally recognized inde-
 24 pendent standards of current medical practice, such

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

3 “(5) SUBSTANCE USE DISORDER BENEFITS.—
 4 The term ‘substance use disorder benefits’ means
 5 benefits with respect to services related to a sub-
 6 stance use disorder, defined consistently with gen-
 7 erally recognized independent standards of current
 8 medical practice, such as the Diagnostic and Statis-
 9 tical Manual of Mental Disorders of the American
 10 Psychiatric Association.”.

11 (3) STANDARDS FOR PARITY IN REIMBURSE-
 12 MENT RATES.—Section 712(a) of the Employee Re-
 13 tirement Income Security Act of 1974 (29 U.S.C.
 14 1185a(a)), as amended by paragraph (1), is further
 15 amended by adding at the end the following:

16 “(10) STANDARDS FOR PARITY IN REIMBURSE-
 17 MENT RATES.—

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

1 medical and surgical benefits, based on a com-
 2 parative analysis conducted by such Secretaries
 3 using data submitted by group health plans and
 4 health insurance issuers, provider associations,
 5 and other experts related to the cost of care de-
 6 livery for mental health and substance use dis-
 7 order benefits.

8 “(B) REQUESTS FOR DATA.—Group health
 9 plans and health insurance issuers shall comply
 10 with any request for data issued by the Sec-
 11 retary, the Secretary of Health and Human
 12 Services, and the Secretary of the Treasury for
 13 purposes of developing the standards under
 14 subparagraph (A).

15 “(C) EFFECTIVE DATE.—The regulations
 16 promulgated under subparagraph (A) shall
 17 apply to group health plans and health insur-
 18 ance issuers offering group health insurance
 19 coverage beginning in the first plan year that
 20 begins after issuance of the final regulations.”.

21 (c) IRC.—

22 (1) NETWORK ADEQUACY REQUIREMENTS.—
 23 Section 9812(a) of the Internal Revenue Code of
 24 1986 is amended by adding at the end the following:

25 “(9) NETWORK ADEQUACY REQUIREMENTS.—

1 “(A) IN GENERAL.—The Secretary, the
2 Secretary of Health and Human Services, and
3 the Secretary of Labor shall issue regulations
4 establishing national quantitative standards for
5 mental health and substance use disorder net-
6 work adequacy. Such standards shall consider—

7 “(i) the ratio of in-network mental
8 health providers, separated by professional
9 type of mental health provider, to partici-
10 pants, beneficiaries, and enrollees in a
11 group health plan;

12 “(ii) the ratio of in-network substance
13 use disorder providers, separated by pro-
14 fessional type of substance use disorder
15 provider, to participants, beneficiaries, and
16 enrollees in a group health plan;

17 “(iii) separately, for each of mental
18 health services and substance use disorder
19 services—

20 “(I) geographic accessibility of
21 providers;

22 “(II) geographic variation and
23 population dispersion;

24 “(III) waiting times for appoint-
25 ments with participating providers;

1 “(IV) hours of operation for par-
2 ticipating providers;

3 “(V) the ability of the network to
4 meet the needs of participants, bene-
5 ficiaries, and enrollees, including low-
6 income individuals, individuals who
7 are members of a racial or ethnic mi-
8 nority, individuals who live in a health
9 professional shortage area, children
10 and adults with serious, chronic, and
11 complex health conditions, individuals
12 with physical or mental disabilities or
13 substance use disorders, pediatric
14 populations, and individuals with lim-
15 ited English proficiency;

16 “(VI) the availability of in-person
17 services, telehealth services, and hy-
18 brid services to serve the needs of par-
19 ticipants, beneficiaries, and enrollees;
20 and

21 “(VII) the percentage of in-net-
22 work providers who have submitted a
23 claim for payment during the previous
24 6 months; and

1 “(iv) other standards as determined
2 by the Secretary, the Secretary of Health
3 and Human Services, and the Secretary of
4 Labor.

5 “(B) TIMING.—

6 “(i) ISSUANCE.—The Secretary, the
7 Secretary of Health and Human Services,
8 and the Secretary of Labor shall—

9 “(I) issue proposed regulations
10 required under subparagraph (A) not
11 later than 2 years after the date of
12 enactment of the Behavioral Health
13 Network and Directory Improvement
14 Act; and

15 “(II) issue final regulations
16 under subparagraph (A) not later
17 than 1 year thereafter.

18 “(ii) EFFECTIVE DATE.—The regula-
19 tions promulgated under this paragraph
20 shall take effect in the first plan year that
21 begins after the date on which such final
22 regulations are issued.

23 “(C) AUDITS.—The Secretary, the Sec-
24 retary of Health and Human Services, and the
25 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-

1 tical Manual of Mental Disorders of the American
2 Psychiatric Association.”.

3 (3) STANDARDS FOR PARITY IN REIMBURSE-
4 MENT RATES.—Section 9812(a) of the Internal Rev-
5 enue Code of 1986, as amended by paragraph (1),
6 is further amended by adding at the end the fol-
7 lowing:

8 “(10) STANDARDS FOR PARITY IN REIMBURSE-
9 MENT RATES.—

10 “(A) IN GENERAL.—Not later than 2 years
11 after the date of enactment of the Behavioral
12 Health Network and Directory Improvement
13 Act, the Secretary, the Secretary of Health and
14 Human Services, and the Secretary of Labor
15 shall issue regulations on a standard for parity
16 in reimbursement rates for mental health or
17 substance use disorder benefits and medical and
18 surgical benefits, based on a comparative anal-
19 ysis conducted by such Secretaries using data
20 submitted by group health plans, provider asso-
21 ciations, and other experts related to the cost of
22 care delivery for mental health and substance
23 use disorder benefits.

24 “(B) REQUESTS FOR DATA.—Group health
25 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,

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

3 “(1) establishing or supporting State and Trib-
4 al mental health and substance use disorder parity
5 ombudsman programs to—

6 “(A) educate consumers about the mental
7 health and substance use disorder coverage in
8 individual plans, group health plans, self-in-
9 sured plans, and State Medicaid managed care
10 plans;

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

16 “(C) assist consumers in exercising their
17 rights under the provisions of part D, including
18 resolving problems related to a group health
19 plan or health insurance issuer erroneously
20 charging a consumer out-of-network rates for
21 services listed in-network on the group health
22 plan or health insurance issuer’s provider direc-
23 tory;

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

1 stance use disorder coverage (including poten-
2 tial violations of the mental health and sub-
3 stance use disorder parity laws) on behalf of
4 consumers;

5 “(E) maintain a toll-free hotline and
6 website for consumers;

7 “(F) collect, track, and quantify problems
8 and inquiries encountered by consumers; and

9 “(G) other activities as defined by the Sec-
10 retary; and

11 “(2) provide support and training for such
12 State and Tribal mental health parity ombudsman
13 programs (such as through the establishment of a
14 mental health parity ombudsman program resource
15 center).

16 “(b) ELIGIBILITY.—To be eligible to receive a grant
17 under this section, a State, Indian Tribe, or Tribal organi-
18 zation shall designate an ombudsman or consumer assist-
19 ance program or other independent entity that—

20 “(1) has specialized knowledge of mental health
21 conditions and substance use disorders and experi-
22 ence resolving inquiries and complaints; and

23 “(2) directly, or in coordination with depart-
24 ments of insurance, and consumer assistance organi-
25 zations, receives and responds to inquiries and com-

1 plaints concerning access to mental health and sub-
2 stance use disorder services.

3 “(c) CRITERIA.—A State, Indian Tribe, or Tribal or-
4 ganization that receives a grant under this section shall
5 comply with criteria established by the Secretary for car-
6 rying out activities under such grant.

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

9 “(1) collect and report data to the Secretary,
10 State legislature, and relevant State agencies, in-
11 cluding the departments of insurance and the State
12 attorney general, on the numbers and types of prob-
13 lems and inquiries encountered by individuals with
14 respect to access to behavioral health services; and

15 “(2) report to the Secretary on how identified
16 problems were addressed, including through prom-
17 ising practices related to responding to mental
18 health and substance use disorder coverage issues,
19 including appeals and education.

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

1 “(f) DEFINITIONS.—In this section, the terms ‘In-
 2 dian Tribe’ and ‘Tribal organization’ have the meanings
 3 given such terms in section 4 of the Indian Self-Deter-
 4 mination and Education Assistance Act.

5 “(g) AUTHORIZATION OF APPROPRIATIONS.—To
 6 carry out this section, there are authorized to be appro-
 7 priated \$20,000,000 for fiscal year 2024 and \$10,000,000
 8 for fiscal year 2025 and each fiscal year thereafter.”.

9 **SEC. 6. REPORT TO CONGRESS.**

10 (a) IN GENERAL.—Not later than 6 years after the
 11 date of enactment of this Act and every 2 years for the
 12 next 10 years, the Secretary of Health and Human Serv-
 13 ices, the Secretary of Labor, and the Secretary of the
 14 Treasury (collectively referred to in this section as the
 15 “Secretaries”) shall jointly submit to Congress and make
 16 publicly available a report to assess the prevalence of ghost
 17 networks and the adequacy of mental health and sub-
 18 stance use disorder networks, in accordance with section
 19 2726(a)(9) of the Public Health Service Act, section
 20 712(a)(9) of the Employee Retirement Income Security
 21 Act of 1974, and section 9812(a)(9) of the Internal Rev-
 22 enue Code of 1986, as amended by section 4. Such report
 23 shall include the following:

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

1 the Secretaries to be out of compliance with the pro-
2 vider directory requirements under section 2799A–5
3 of the Public Health Service Act, section 720 of the
4 Employee Retirement Income Security Act of 1974,
5 and section 9820 of the Internal Revenue Code of
6 1986, as amended by section 2.

7 (2) Aggregate information about group health
8 plans and health insurance issuers determined by
9 the Secretaries to be out of compliance with the re-
10 quirements for parity in mental health and sub-
11 stance use disorder benefits under section 2726 of
12 the Public Health Service Act (42 U.S.C. 300gg–
13 26), section 712 of the Employee Retirement Income
14 Security Act of 1974 (29 U.S.C. 1185a), and section
15 9812 of the Internal Revenue Code of 1986, as
16 amended by section 4.

17 (3) A summary of findings through audits, in
18 the aggregate, under section 2799A–5(a)(7)(C) of
19 the Public Health Service Act, section 720(a)(7)(C)
20 of the Employee Retirement Income Security Act of
21 1974, and section 9820(a)(7)(C) of the Internal
22 Revenue Code of 1986, as amended by section 2, in-
23 cluding—

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

1 (B) the accuracy of provider directory in-
2 formation, sectioned out by accuracy of the pro-
3 vider's name, address, specialty, telephone num-
4 ber, digital contact information, whether the
5 providers are accepting new patients, in-net-
6 work status, linguistic- and cultural-com-
7 petency, and availability of medications for
8 opioid use disorder;

9 (C) the number of plans and individuals
10 enrolled in a group health plan or group or in-
11 dividual health insurance coverage that offers a
12 mental health and substance use disorder net-
13 work that meets the network adequacy stand-
14 ards under, as applicable, section 2799A-5 of
15 the Public Health Service Act, section 720 of
16 the Employee Retirement Income Security Act
17 of 1974, or section 9820 of the Internal Rev-
18 enue Code of 1986, as amended by section 2;
19 and

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

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

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

3 (b) DEFINITION.—In this section, the term “ghost
4 network” has the meaning given such term in section
5 2799A–5(a)(8) of the Public Health Service Act, section
6 720(a)(8) of the Employee Retirement Income Security
7 Act of 1974, and section 9820(a)(8) of the Internal Rev-
8 enue Code of 1986, as amended by section 2.

9 **SEC. 7. AUTHORIZATION OF APPROPRIATIONS.**

10 To carry out this Act, including the amendments
11 made by this Act, in addition to amounts otherwise made
12 available for such purposes, there are authorized to be ap-
13 propriated \$28,000,000 for each of fiscal years 2023
14 through 2032.

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