To strengthen parity in mental health and substance use disorder benefits.

IN THE HOUSE OF REPRESENTATIVES

Mr. KENNEDY introduced the following bill; which was referred to the Committee on

A BILL

To strengthen parity in mental health and substance use disorder benefits.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Behavioral Health Cov-
erage Transparency Act”.

SEC. 2. STRENGTHENING PARITY IN MENTAL HEALTH AND

SUBSTANCE USE DISORDER BENEFITS.

(a) Public Health Service Act.—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 new paragraph:

“(8) DISCLOSURE AND ENFORCEMENT REQUIREMENTS.—

“(A) DISCLOSURE REQUIREMENTS.—

“(i) REGULATIONS.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, shall issue regulations for carrying out this section, including an explanation of documents that group health plans and health insurance issuers offering group or individual health insurance coverage shall disclose in accordance with clause (ii), the process governing the disclosure of such documents, and analyses that such plans and issuers shall conduct in order to demonstrate compliance with this section.

“(ii) DISCLOSURE REQUIREMENTS.—

The documents required to be disclosed by a group health plan or a health insurance issuer offering group or individual health insurance coverage under clause (i) shall
include an annual report that details the specific analyses performed to ensure compliance of such plan or issuer with this section, including any regulation promulgated pursuant to this section. At a minimum, with respect to the application of non-quantitative treatment limitations (in this paragraph referred to as ‘NQTLs’) to benefits under the plan or coverage, such report shall—

“(I) identify the specific factors the plan or issuer used in performing its NQTLs analysis;

“(II) identify and define the specific evidentiary standards relied on to evaluate such factors;

“(III) describe how the evidentiary standards are applied to each service category for mental health benefits, substance use disorder benefits, medical benefits, and surgical benefits;

“(IV) disclose the results of the analyses of the specific evidentiary
standards in each service category; and

“(V) disclose the specific findings of the plan or issuer in each service category and the conclusions reached with respect to whether the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to medical and surgical benefits in the same classification.

“(iii) GUIDANCE.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage on how to satisfy the requirements of this section, with respect to
making information available to current and potential participants and beneficiaries. Such information shall include—

“(I) certificate of coverage documents and instruments under which the plan or coverage involved is administered and operated that specify, include, or refer to procedures, formulas, and methodologies applied to determine a participant’s or beneficiary’s benefit under the plan or coverage, regardless of whether such information is contained in a document designated as the ‘plan document’; and

“(II) a disclosure of how the plan or issuer involved has provided that processes, strategies, evidentiary standards, and other factors used in applying the NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs
to medical and surgical benefits in the
same classification.

“(iv) DEFINITIONS.—In this para-
graph and paragraph (7), the terms ‘non-
quantitative treatment limitations’, ‘com-
parable to’, and ‘applied no more strin-
gently than’ have the meanings given such
terms in sections 146.136 and 147.160 of
title 45, Code of Federal Regulations (or
any successor regulation).

“(B) ENFORCEMENT.—

“(i) PROCESS FOR COMPLAINTS.—Not
later than 6 months after the date of en-
actment of this paragraph, the Secretary,
in cooperation with the Secretaries of
Labor and the Treasury, shall, with re-
spect to group health plans and health in-
surance issuers offering group or indi-
vidual health insurance coverage, 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.

“(ii) AUDITS.—

“(I) RANDOMIZED AUDITS.—Beginning 1 year after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, as applicable, shall conduct randomized audits of group health plans and health insurance issuers offering group or individual health insurance coverage to determine compliance with this section. Such audits shall be conducted on no fewer than 12 plans or coverages per plan year.

“(II) ADDITIONAL AUDITS.—Beginning 1 year after the date of enactment of this paragraph, in the case of a group health plan or health insurance issuer offering group or individual health insurance coverage with
respect to which any claim has been filed during a plan year, the Secretary, in cooperation with the Secretaries of Labor and the Treasury, as applicable, may audit the books and records of such plan or issuer to determine compliance with this section.

“(iii) DENIAL RATES.—The Secretary, in cooperation with the Secretaries of Labor and the Treasury, shall collect information on the rates of and reasons for denial by group health plans and health insurance issuers offering group or individual health insurance coverage of claims for outpatient and inpatient mental health and substance use disorder benefits compared to the rates of and reasons for denial of claims for medical and surgical benefits. For the first plan year that begins on or after the date that is 2 years after the date of enactment of this paragraph, and each subsequent plan year, the Secretary, in such cooperation, 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 information collected under the previous sentence with respect to the previous plan year.

“(C) Effective Date.—Any requirements of group health plans and health insurance issuers offering group or individual health insurance coverage that are included in the regulations issued under subparagraph (A)(i), including the requirement described in subparagraph (A)(ii) to disclose documents, shall have an effective date of 1 year after the date of enactment of this paragraph.”.

(b) Employee Retirement Income Security Act of 1974.—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 new paragraph:

“(6) Disclosure and Enforcement Requirements.—

“(A) Disclosure requirements.—

“(i) Regulations.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human
Services and the Treasury, shall issue regulations for carrying out this section, including an explanation of documents that a group health plan (or health insurance issuer offering health insurance coverage in connection with such a plan) shall disclose in accordance with clause (ii), the process governing the disclosure of such documents, and analyses that such plans and issuers shall conduct in order to demonstrate compliance with this section.

“(ii) DISCLOSURE REQUIREMENTS.—

The documents required to be disclosed by a group health plan (or a health insurance issuer offering health insurance coverage in connection with such a plan) under clause (i) shall include an annual report that details the specific analyses performed to ensure compliance of such plan or issuer with this section, including any regulation promulgated pursuant to this section. At a minimum, with respect to the application of nonquantitative treatment limitations (in this paragraph referred to as ‘NQTLs’)}
to benefits under the plan or coverage, such report shall—

“(I) identify the specific factors the plan or issuer used in performing its NQTLs analysis;

“(II) identify and define the specific evidentiary standards relied on to evaluate such factors;

“(III) describe how the evidentiary standards are applied to each service category for mental health benefits, substance use disorder benefits, medical benefits, and surgical benefits;

“(IV) disclose the results of the analyses of the specific evidentiary standards in each service category; and

“(V) disclose the specific findings of the plan or issuer in each service category and the conclusions reached with respect to whether the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to mental health or substance
use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to medical and surgical benefits in the same classification.

“(iii) GUIDANCE.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, shall issue guidance to group health plans (and health insurance issuers offering health insurance coverage in connection with such plans) on how to satisfy the requirements of this section, with respect to making information available to current and potential participants and beneficiaries. Such information shall include—

“(I) certificate of coverage documents and instruments under which the plan or coverage involved is administered and operated that specify, include, or refer to procedures, for-
mulas, and methodologies applied to determine a participant’s or beneficiary’s benefit under the plan or coverage, regardless of whether such information is contained in a document designated as the ‘plan document’; and

“(II) a disclosure of how the plan or issuer involved has provided that processes, strategies, evidentiary standards, and other factors used in applying the NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to medical and surgical benefits in the same classification.

“(iv) DEFINITIONS.—In this paragraph, the terms ‘nonquantitative treatment limitations’, ‘comparable to’, and ‘applied no more stringently than’ have the meanings given such terms in sections 146.136 and 147.160 of title 45, Code of
Federal Regulations (or any successor regulation).

“(B) ENFORCEMENT.—

“(i) PROCESS FOR COMPLAINTS.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, shall, with respect to group health plans (and health insurance issuers offering health insurance coverage in connection with such plans), 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.

“(ii) AUDITS.—
“(I) RANDOMIZED AUDITS.—Beginning 1 year after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, as applicable, shall conduct randomized audits of group health plans (and health insurance issuers offering health insurance coverage in connection with such plans) to determine compliance with this section. Such audits shall be conducted on no fewer than 12 plans or coverages per plan year.

“(II) ADDITIONAL AUDITS.—Beginning 1 year after the date of enactment of this paragraph, in the case of a group health plan (or health insurance issuer offering health insurance coverage in connection with such a plan) with respect to which any claim has been filed during a plan year, the Secretary, in cooperation with the Secretaries of Health and Human Services and the Treasury, as applica-
ble, may audit the books and records
of such plan or issuer to determine
compliance with this section.

“(iii) DENIAL RATES.—The Secretary,
in cooperation with the Secretaries of
Health and Human Services and the
Treasury, shall collect information on the
rates of and reasons for denial by group
health plans (and health insurance issuers
offering health insurance coverage in con-
nection with such plans) of claims for out-
patient and inpatient mental health and
substance use disorder benefits compared
to the rates of and reasons for denial of
claims for medical and surgical benefits.
For the first plan year that begins on or
after the date that is 2 years after the date
of enactment of this paragraph, and each
subsequent plan year, the Secretary, in
such cooperation, shall submit to the Com-
mittee on Energy and Commerce of the
House of Representatives and the Com-
mittee on Health, Education, Labor, and
Pensions of the Senate the information col-
lected under the previous sentence with re-
pect to the previous plan year.

“(C) Effective Date.—Any require-
ments of group health plans (or health insur-
ance issuers offering health insurance coverage
in connection with such plans) that are included
in the regulations issued under subparagraph
(A)(i), including the requirement described in
subparagraph (A)(ii) to disclose documents,
shall have an effective date of 1 year after the
date of enactment of this paragraph.”.

(c) Internal Revenue Code of 1986.—Section
9812(a) of the Internal Revenue Code of 1986 is amended
by adding at the end the following new paragraph:

“(6) Disclosure and Enforcement Re-
quirements.—

“(A) Disclosure Requirements.—

“(i) Regulations.—Not later than 6
months after the date of enactment of this
paragraph, the Secretary, in cooperation
with the Secretaries of Health and Human
Services and Labor, shall issue regulations
for carrying out this section, including an
explanation of documents that group
health plans shall disclose in accordance
with clause (ii), the process governing the
disclosure of such documents, and analyses
that such plans shall conduct in order to
demonstrate compliance with this section.

“(ii) DISCLOSURE REQUIREMENTS.—

The documents required to be disclosed by
a group health plan under clause (i) shall
include an annual report that details the
specific analyses performed to ensure com-
pliance of such plan with this section, in-
cluding any regulation promulgated pursuant
to such section. At a minimum, with
respect to the application of nonquantita-
tive treatment limitations (in this para-
graph referred to as ‘NQTLs’) to benefits
under the plan, such report shall—

“(I) identify the specific factors
the plan used in performing its
NQTLs analysis;

“(II) identify and define the spe-
cific evidentiary standards relied on to
evaluate such factors;

“(III) describe how the evi-
dentiary standards are applied to each
service category for mental health
benefits, substance use disorder benefits, medical benefits, and surgical benefits;

“(IV) disclose the results of the analyses of the specific evidentiary standards in each service category; and

“(V) disclose the specific findings of the plan in each service category and the conclusions reached with respect to whether the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to medical and surgical benefits in the same classification.

“(iii) GUIDANCE.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human
Services and Labor, shall issue guidance to group health plans on how to satisfy the requirements of this section, with respect to making information available to current and potential participants and beneficiaries. Such information shall include—

“(I) certificate of coverage documents and instruments under which the plan involved is administered and operated that specify, include, or refer to procedures, formulas, and methodologies applied to determine a participant’s or beneficiary’s benefit under the plan, regardless of whether such information is contained in a document designated as the ‘plan document’; and

“(II) a disclosure of how the plan involved has provided that processes, strategies, evidentiary standards, and other factors used in applying the NQTLs to mental health or substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evi-
dentistry standards, or other factors used in applying the NQTLs to medical and surgical benefits in the same classification.

“(iv) DEFINITIONS.—In this paragraph, the terms ‘nonquantitative treatment limitations’, ‘comparable to’, and ‘applied no more stringently than’ have the meanings given such terms in sections 146.136 and 147.160 of title 45, Code of Federal Regulations (or any successor regulation).

“(B) ENFORCEMENT.—

“(i) PROCESS FOR COMPLAINTS.—Not later than 6 months after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and Labor, shall, with respect to group health plans, 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 com-
plaints 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.

“(ii) AUDITS.—

“(I) RANDOMIZED AUDITS.—Beginning 1 year after the date of enactment of this paragraph, the Secretary, in cooperation with the Secretaries of Health and Human Services and Labor, as applicable, shall conduct randomized audits of group health plans to determine compliance with this section. Such audits shall be conducted on no fewer than 12 plans per plan year.

“(II) ADDITIONAL AUDITS.—Beginning 1 year after the date of enactment of this paragraph, in the case of a group health plan with respect to which any claim has been filed during a plan year, the Secretary, in cooperation with the Secretaries of Health and Human Services and Labor, as
applicable, may audit the books and
records of such plan to determine
compliance with this section.

“(iii) DENIAL RATES.—The Secretary,
in cooperation with the Secretaries of
Health and Human Services and Labor,
shall collect information on the rates of
and reasons for denial by group health
plans of claims for outpatient and inpa-
tient mental health and substance use dis-
order benefits compared to the rates of
and reasons for denial of claims for med-
ical and surgical benefits. For the first
plan year that begins on or after the date
that is 2 years after the date of enactment
of this paragraph, and each subsequent
plan year, the Secretary, in such cooper-
ation, shall submit to the Committee on En-
ergy and Commerce of the House of Rep-
resentatives and the Committee on Health,
Education, Labor, and Pensions of the
Senate the information collected under the
previous sentence with respect to the pre-
vious plan year.
“(C) Effective Date.—Any requirements of group health plans that are included in the regulations issued under subparagraph (A)(i), including the requirement described in subparagraph (A)(ii) to disclose documents, shall have an effective date of 1 year after the date of enactment of this paragraph.”.

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.

(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 Laws.—The term “mental health parity laws” 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 law that applies the requirements under any of the sections described in subparagraph (A), (B), or (C), or requirements that are substantially similar to those provided 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.

(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 head of any other applicable agency, shall establish a consumer parity unit with functions that include—

(1) facilitating the centralized collection of, monitoring of, and response to consumer 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 in-
clude enhancing a website portal in existence on
the date of enactment of this Act; and

(2) providing information to health care con-
sumers regarding the disclosure requirements and
enforcement under section 2726(a)(8) of the Public
Health Service Act, section 712(a)(6) of the Em-
ployee Retirement Income Security Act of 1974, and
section 9812(a)(6) of the Internal Revenue Code of
1986, as added by section 2.

(c) WEBSITE PORTAL.—The Secretary, in consulta-
tion with the Secretary of Labor, the Secretary of the
Treasury, and the head of any other applicable agency,
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, section 712 of the Employee Re-
tirement Income Security Act of 1974, or section
9812 of the Internal Revenue Code of 1986, respec-
tively, including the amendments to such sections made by section 2;

(2) de-identified 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; and

(3) any information on rates of or reasons for denial collected by the Secretary, the Secretary of Labor, or the Secretary of the Treasury, pursuant to subsection (a)(8)(B)(iii) of such section 2726, subsection (a)(6)(B)(iii) of such section 712, or subsection (a)(6)(B)(iii) of such section 9812, respectively.

(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 head of any other applicable agency, shall establish reasonable procedures for the consumer parity unit established under this section to provide a timely response (in writing if appropriate) to consumers re-
garding complaints received by the unit against, or inquiries concerning, a covered plan, including—

(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) 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 follow up on the complaint or inquiry.

(2) Timely response to regulators.—A covered plan shall provide a timely response (in writing if appropriate) to the appropriate State or Federal enforcement agency having jurisdiction over such plan 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, in
a timely manner, comply with a consumer re-
quest for information in the control or posses-
sion of such covered plan concerning the cov-
erage the consumer obtained from such covered
plan.

(B) Exceptions.—Notwithstanding sub-
paragraph (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.

(c) Reports.—
(1) IN GENERAL.—Not later than March 31 of each year, the Secretary, in consultation with the Secretary of Labor, the Secretary of the Treasury, and the head of any other applicable agency, 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.

(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—

(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 permission for the disclosure
of such information by the covered plan to such
unit; or

(B) as may be specifically permitted or re-
quired under other applicable provisions of law,
including HIPAA privacy and security law as
defined in section 3009(a) of the Public Health
Service Act (42 U.S.C. 300jj–19(a)).

(h) COLLABORATION.—

(1) AGREEMENTS WITH OTHER AGENCIES.—
The Secretary, the Secretary of Labor, the Secretary
of the Treasury, and the head of any other applica-
ble agency, shall enter into a memorandum of under-
standing with any affected Federal regulatory agen-
cy regarding procedures by which any covered plan,
and any other agency having jurisdiction over a cov-
ered plan, shall comply with this section.

(2) AGREEMENTS WITH STATES.—To the ex-
tent 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 sat-
isfied 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.