II

118TH CONGRESS
2D SESSION

S. 4023

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

IN THE SENATE OF THE UNITED STATES

MARCH 21, 2024

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

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A BILL

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

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; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Behavioral Health Network and Directory Improvement
6 Act”.

7 (b) TABLE OF CONTENTS.—The table of contents for
8 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Protecting patients and improving the accuracy of provider directory information.

Sec. 3. Provider requirements to protect patients and improve the accuracy of provider directory information.
Sec. 4. Strengthening mental health and substance use disorder parity requirements.
Sec. 5. State and Tribal ombudsman programs relating to mental health and substance use disorder parity.
Sec. 6. Report to Congress.
Sec. 7. Authorization of appropriations.

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

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

(1) in subsection (a)—

(A) in paragraph (1)—

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

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

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

(iv) by adding at the end the following:

''(E) ensure that any directory, including the database described in subparagraph (C), containing provider directory information with respect to such plan or such coverage complies with the requirements developed by the appro-

1 priate agencies in accordance with paragraph
2 (6) in order to ensure that participants, bene-
3 ficiaries, and enrollees are able to identify ac-
4 tively participating health care providers and
5 health care facilities.'';
6 (B) in paragraph (3)—
7 (i) in the matter preceding subpara-
8 graph (A), by striking '', in the case such
9 request is made through a telephone call'';
10 and
11 (ii) in subparagraph (A), by striking
12 ''call is received, through a written elec-
13 tronic or print (as requested by such indi-
14 vidual) communication'' and inserting ''a
15 request is received, by telephone, or
16 through a written electronic or print com-
17 munication (as requested by such indi-
18 vidual)'';
19 (C) in paragraph (4)—
20 (i) in subparagraph (A), by striking
21 ''and'' at the end;
22 (ii) in subparagraph (B), by striking
23 the period and inserting ''; and''; and
24 (iii) by adding at the end the fol-
25 lowing:

1 "(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, as appropriate, the State consumer assistance program or ombudsman or the Employee Benefits Security Administration for more information.";

12 (D) 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, as appropriate, the State consumer assistance program or ombudsman or the Employee Benefits Security Administration for more information.";

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

1 (F) 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 the Treas-
7 ury, shall—
8 "(A) not later than 4 years after the date
9 of enactment of the Behavioral Health Network
10 and Directory Improvement Act, issue final reg-
11 ulations further defining the term 'ghost net-
12 work' (as defined in paragraph (8)); and
13 "(B) not later than 4 years after the date
14 of enactment of the Behavioral Health Network
15 and Directory Improvement Act, issue final reg-
16 ulations, subregulatory guidance, or program
17 instruction on how to assess ghost networks in
18 health plan directories including reasonable as-
19 sumptions related to statistics and research
20 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

Directory Improvement Act, each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, at such time as the Secretary, in coordination with the Secretary of Labor and the Secretary of the Treasury, shall require, but not less frequently than annually, the directory data described in paragraph (a)(4), in a machine readable format (as defined in section 147.210(a)(2)(xiv) of title 45, Code of Federal Regulations (or any successor regulations)). A health insurance issuer or a third party administrator of a group health plan may submit such information for all health insurance coverage or all group health plans, collectively, that such issuer or administrator administers. 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 enact-

1 ment of the Behavioral Health Network
2 and Directory Improvement Act, each
3 group health plan and health insurance
4 issuer offering group or individual health
5 insurance coverage shall conduct an annual
6 directory audit, through an independent
7 entity not associated with the health plan
8 or issuer, that considers the factors de-
9 scribed in clause (ii)(I)(aa) and follows the
10 guidelines developed under clause
11 (ii)(I)(bb).

12 ''(ii) INFORMATION TO BE IN-
13 CLUDED.—

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

17 ''(aa) develop a list of infor-
18 mation required to be included;
19 and

20 ''(bb) provide guidelines for
21 carrying out such audits, for use
22 by group health plans and health
23 insurance issuers, on—

24 ''(AA) the reasonable
25 assumptions and research

1 methods to select a reasonable sample in order to assess provider directory information accuracy; and

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

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

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

18 "(bb) The number of in-network items or services paid on behalf of participants, beneficiaries, and enrollees in the plan or coverage to providers or facilities who have a network provider contract with the health plan or issuer and were not listed in the

1 directory of the health plan or
2 health insurance coverage for the
3 audit period.

4 "(cc) The resources of the
5 plan or issuer to help partici-
6 pants, beneficiaries, and enrollees
7 locate an accurately listed in-net-
8 work provider who is accepting
9 new patients.

10 "(dd) The proportion of par-
11 ticipants, beneficiaries, and en-
12 rollees using out-of-network pro-
13 viders for mental health and sub-
14 stance use disorder services, and
15 the proportion of participants,
16 beneficiaries, and enrollees using
17 out-of-network providers and fa-
18 cilities for medical and surgical
19 services.

20 "(ee) Documentation that
21 the plan or issuer verifies the ac-
22 curacy of the provider directory
23 information every 90 days.

24 "(ff) Other factors as deter-
25 mined by the Secretary.

1 "(iii) STANDARDS FOR REPORTING.—
2 An audit under this subparagraph is com-
3 plete if all of the following conditions are
4 met:
5 "(I) The audit report includes
6 the following:
7 "(aa) A statement by the
8 independent auditor that, to the
9 best of the auditor's knowledge,
10 the report is complete and accu-
11 rate, and that reasonable as-
12 sumptions related to statistics
13 and research methods have been
14 complied with.
15 "(bb) A statement explain-
16 ing the assumptions, statistics,
17 and methods used to select the
18 sample and assess provider direc-
19 tory information accuracy.
20 "(cc) Such other require-
21 ments as the Secretary deter-
22 mines necessary.
23 "(II) The group health plan or
24 health insurer issuer makes the inde-

1 pendent audit available on a public
2 website.
3 "(iv) RULEMAKING.—The Secretary,
4 the Secretary of Labor, and the Secretary
5 of the Treasury shall issue interim final
6 regulations (without prior notice and com-
7 ment as generally required under section
8 553 of title 5, United States Code) con-
9 cerning the national standards for con-
10 ducting audits under this subparagraph,
11 not later than 2 years after the date of en-
12 actment of the Behavioral Health Network
13 and Directory Improvement Act.
14 "(C) AUDITS BY THE SECRETARY.—
15 "(i) IN GENERAL.—Beginning not
16 later than the fourth plan year after the
17 date of enactment of the Behavioral
18 Health Network and Directory Improve-
19 ment Act, the Secretary shall conduct an-
20 nual audits to ensure compliance with the
21 auditing requirements under subparagraph
22 (B).
23 "(ii) SELECTION OF PLANS AND
24 ISSUERS.—The Secretary, the Secretary of
25 Labor, and the Secretary of the Treasury

1 (referred to in this clause as the 'Secre-
2 taries'), jointly, shall conduct annual au-
3 dits of the submissions under subpara-
4 graph (B) of a total of not fewer than 10
5 group health plans or health insurance
6 issuers offering group or individual health
7 insurance coverage, as determined by the
8 Secretaries, that are the subjects of com-
9 plaints about ghost networks or other com-
10 plaints, or that are randomly selected by
11 the Secretaries.''; and
12 (G) in paragraph (8), as so redesignated—
13 (i) in the paragraph heading, by strik-
14 ing ''DEFINITION'' and inserting ''DEFINI-
15 TIONS'';
16 (ii) by striking ''For purposes of this
17 subsection, the term'' and inserting the fol-
18 lowing: ''For purposes of this subsection:
19 ''(A) PROVIDER DIRECTORY INFORMA-
20 TION.—The term'';
21 (iii) by striking ''health insurance cov-
22 erage, the name, address'' and inserting
23 ''health insurance coverage—
24 ''(i) the name, address where the pro-
25 vider regularly sees patients'';

1 (iv) by striking the period and inserting "; and"; and
3 (v) by adding at the end the following:
4 "(ii) with respect to each such provider or facility—
6 "(I) whether such provider or facility is accepting new patients;
8 "(II) the languages spoken and the availability of language translators for specified languages at each health care facility listed in the directory;
12 "(III) whether the provider or facility offers medication-assisted treatment for opioid use disorder;
15 "(IV) the State license number;
16 "(V) the national provider identifier;
18 "(VI) the age groups served by the provider or facility, such as pediatric, adolescent, adult, or geriatric populations;
22 "(VII) whether such provider or facility offers in-person services, telehealth services, or both;

1 "(VIII) the cost-sharing tier, if
2 applicable; and
3 "(IX) health insurance plans ac-
4 cepted (including the plan identifier
5 and type of plan).
6 "(B) GHOST NETWORK.—The term 'ghost
7 network' means a group health plan or group or
8 individual health insurance coverage for which
9 the provider directory information describing
10 the network of such plan or coverage—
11 "(i) includes inaccurate contact infor-
12 mation with respect to a substantial share
13 of included listings and providers who are
14 part of the network;
15 "(ii) includes a substantial number of
16 providers and facilities (as specified by the
17 Secretary, in coordination with the Sec-
18 retary of Labor and the Secretary of the
19 Treasury) in a specialty who are not ac-
20 cepting new patients within a time period
21 specified by such secretaries;
22 "(iii) includes a substantial number of
23 providers and facilities that are not part of
24 the network; or

1 "(iv) omits a substantial number of
2 providers and facilities that are part of the
3 network."; and
4 (2) in subsection (b)—
5 (A) in paragraph (1), by striking "and if
6 either of the criteria described in paragraph (2)
7 applies with respect to such participant, bene-
8 ficiary, or enrollee and item or service"; and
9 (B) by striking paragraph (2) and insert-
10 ing the following:
11 "(2) RECONCILIATION REQUIREMENT.—If a
12 nonparticipating provider was listed as a partici-
13 pating provider in the posted provider directory
14 database, the group health plan or health insurance
15 issuer shall, not later than 30 days after receiving
16 the request for payment, notify the participant, ben-
17 eficiary, or enrollee, in plain language, that the par-
18 ticipant, beneficiary, or enrollee may be eligible for
19 a refund from the group health plan or health insur-
20 ance issuer if such participant, beneficiary, or en-
21 rollee paid the out of network cost-sharing and did
22 not receive a refund under section 2799B–9(b).".
23 (b) ERISA.—

1 (1) IN GENERAL.—Section 720 of the Employee
2 Retirement Income Security Act of 1974 (29 U.S.C.
3 1185i) is amended—
4 (A) in subsection (a)—
5 (i) in paragraph (1)—
6 (I) by striking ''For plan years
7 beginning on or after January 1,
8 2022, each'' and inserting ''Each'';
9 (II) in subparagraph (C), by
10 striking ''; and'' and inserting a semi-
11 colon;
12 (III) in subparagraph (D), by
13 striking the period and inserting '';
14 and''; and
15 (IV) by adding at the end the fol-
16 lowing:
17 ''(E) ensure that any directory, including
18 the database described in subparagraph (C),
19 containing provider directory information with
20 respect to such plan or such coverage complies
21 with the requirements developed by the appro-
22 priate agencies in accordance with paragraph
23 (6) in order to ensure that participants, bene-
24 ficiaries, and enrollees are able to identify ac-

1 tively participating health care providers and
2 health care facilities.'';
3 (ii) in paragraph (3)—
4 (I) in the matter preceding sub-
5 paragraph (A), by striking '', in the
6 case such request is made through a
7 telephone call''; and
8 (II) in subparagraph (A), by
9 striking ''call is received, through a
10 written electronic or print (as re-
11 quested by such individual) commu-
12 nication'' and inserting ''a request is
13 received, by telephone, or through a
14 written electronic or print communica-
15 tion (as requested by such indi-
16 vidual)'';
17 (iii) in paragraph (4)—
18 (I) in subparagraph (A), by strik-
19 ing ''and'' at the end;
20 (II) in subparagraph (B), by
21 striking the period and inserting '';
22 and''; and
23 (III) by adding at the end the
24 following:

1 "(C) information, in plain language, con-
2 cerning the rights of the participant, bene-
3 ficiary, or enrollee to cost-sharing protections
4 pursuant to subsection (b) in the event of reli-
5 ance on inaccurate provider network informa-
6 tion supplied by a group health plan or health
7 insurance issuer, and contact information for,
8 as appropriate, the State consumer assistance
9 program or ombudsman or the Employee Bene-
10 fits Security Administration for more informa-
11 tion.";

12 (iv) in paragraph (5), by adding at
13 the end the following: "Such information
14 shall include a statement, in plain lan-
15 guage, concerning the rights of the partici-
16 pant, beneficiary, or enrollee to cost-shar-
17 ing protections pursuant to subsection (b)
18 in the event of reliance on inaccurate pro-
19 vider directory information supplied by a
20 group health plan or health insurance
21 issuer, and contact information for, as ap-
22 propriate, the State consumer assistance
23 program or ombudsman or the Employee
24 Benefits Security Administration for more
25 information.";

1 (v) by redesignating paragraphs (6)
2 and (7) as paragraphs (8) and (9), respec-
3 tively;
4 (vi) by inserting after paragraph (5)
5 the following:
6 "(6) PROTECTING PARTICIPANTS, BENE-
7 FICIARIES, AND ENROLLEES FROM GHOST NET-
8 WORKS.—The Secretary, in collaboration with the
9 Secretary of Labor and the Secretary of the Treas-
10 ury, shall—
11 "(A) not later than 4 years after the date
12 of enactment of the Behavioral Health Network
13 and Directory Improvement Act, issue final reg-
14 ulations further defining the term 'ghost net-
15 work' (as defined in paragraph (8)); and
16 "(B) not later than 4 years after the date
17 of enactment of the Behavioral Health Network
18 and Directory Improvement Act, issue final reg-
19 ulations, subregulatory guidance, or program
20 instruction on how to assess ghost networks in
21 health plan directories including reasonable as-
22 sumptions related to statistics and research
23 methods.
24 "(7) DATABASE REPORTING AND AUDITING TO
25 PROTECT AGAINST GHOST NETWORKS.—

1 "(A) REPORTING REQUIREMENTS.—Begin-
2 ning not later than 3 years after the date of en-
3 actment of the Behavioral Health Network and
4 Directory Improvement Act, each group health
5 plan and health insurance issuer offering group
6 health insurance coverage shall submit to the
7 Secretary, at such time as the Secretary, in co-
8 ordination with the Secretary of Health and
9 Human Services and the Secretary of the
10 Treasury, shall require, but not less frequently
11 than annually, the directory data described in
12 paragraph (a)(4), in a machine readable format
13 (as defined in section 147.210(a)(2)(xiv) of title
14 45, Code of Federal Regulations (or any suc-
15 cessor regulations)). A health insurance issuer
16 or a third party administrator of a group health
17 plan may submit such information for all health
18 insurance coverage or all group health plans,
19 collectively, that such issuer or administrator
20 administers. The Secretary, in coordination
21 with the Secretary of Health and Human Serv-
22 ices and the Secretary of the Treasury, shall
23 make data submitted under this subparagraph
24 available on a public website.

1 "(B) PROVIDER DIRECTORY INDEPENDENT
2 AUDIT REQUIREMENTS.—
3 "(i) IN GENERAL.—Beginning not
4 later than 3 years after the date of enact-
5 ment of the Behavioral Health Network
6 and Directory Improvement Act, each
7 group health plan and health insurance
8 issuer offering group health insurance cov-
9 erage shall conduct an annual directory
10 audit, through an independent entity not
11 associated with the health plan or issuer,
12 that considers the factors described in
13 clause (ii)(I)(aa) and follows the guidelines
14 developed under clause (ii)(I)(bb).
15 "(ii) INFORMATION TO BE IN-
16 CLUDED.—
17 "(I) IN GENERAL.—For purposes
18 of carrying out the audits under this
19 subparagraph, the Secretary shall—
20 "(aa) develop a list of infor-
21 mation required to be included;
22 and
23 "(bb) provide guidelines for
24 carrying out such audits, for use

1 by group health plans and health
2 insurance issuers, on—
3 "(AA) the reasonable
4 assumptions and research
5 methods to select a reason-
6 able sample in order to as-
7 sess provider directory infor-
8 mation accuracy; and
9 "(BB) determining the
10 criteria of an eligible audi-
11 tor.
12 "(II) CONTENTS.—The informa-
13 tion listed under subclause (I)(aa)
14 shall include the following:
15 "(aa) The proportion of di-
16 rectory listings of the plan or
17 coverage with inaccurate infor-
18 mation, including incorrect con-
19 tact information, as specified by
20 the Secretary, during the audit
21 period.
22 "(bb) The number of in-net-
23 work items or services paid on
24 behalf of participants, bene-
25 ficiaries, and enrollees in the plan

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

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

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

24 "(ee) Documentation that
25 the plan or issuer verifies the ac-

1 curacy of the provider directory
2 information every 90 days.
3 “(ff) Other factors as deter-
4 mined by the Secretary.
5 “(iii) STANDARDS FOR REPORTING.—
6 An audit under this subparagraph is com-
7 plete if all of the following conditions are
8 met:
9 “(I) The audit report includes
10 the following:
11 “(aa) A statement by the
12 independent auditor that, to the
13 best of the auditor’s knowledge,
14 the report is complete and accu-
15 rate, and that reasonable as-
16 sumptions related to statistics
17 and research methods have been
18 complied with.
19 “(bb) A statement explain-
20 ing the assumptions, statistics,
21 and methods used to select the
22 sample and assess provider direc-
23 tory information accuracy.

1 "(cc) Such other require-
2 ments as the Secretary deter-
3 mines 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 Health and Human Serv-
10 ices, and the Secretary of the Treasury
11 shall issue interim final regulations (with-
12 out prior notice and comment as generally
13 required under section 553 of title 5,
14 United States Code) concerning the na-
15 tional standards for conducting audits
16 under this subparagraph, not later than 2
17 years after the date of enactment of the
18 Behavioral Health Network and Directory
19 Improvement Act.
20 "(C) AUDITS BY THE SECRETARY.—
21 "(i) IN GENERAL.—Beginning not
22 later than the fourth plan year after the
23 date of enactment of the Behavioral
24 Health Network and Directory Improve-
25 ment Act, the Secretary shall conduct an-

1 nual audits to ensure compliance with the
2 auditing requirements under subparagraph
3 (B).
4 "(ii) SELECTION OF PLANS AND
5 ISSUERS.—The Secretary, the Secretary of
6 Health and Human Services, and the Sec-
7 retary of the Treasury (referred to in this
8 clause as the 'Secretaries'), jointly, shall
9 conduct annual audits of the submissions
10 under subparagraph (B) of a total of not
11 fewer than 10 group health plans or health
12 insurance issuers offering group health in-
13 surance coverage, as determined by the
14 Secretaries, that are the subjects of com-
15 plaints about ghost networks or other com-
16 plaints, or that are randomly selected by
17 the Secretaries."; and
18 (vii) in paragraph (8), as so redesig-
19 nated—
20 (I) in the paragraph heading, by
21 striking "DEFINITION" and inserting
22 "DEFINITIONS";
23 (II) by striking "For purposes of
24 this subsection, the term" and insert-

1 ing the following: ''For purposes of
2 this subsection:
3 ''(A) PROVIDER DIRECTORY INFORMA-
4 TION.—The term'';
5 (III) by striking ''health insur-
6 ance coverage, the name, address''
7 and inserting ''health insurance cov-
8 erage—
9 ''(i) the name, address where the pro-
10 vider regularly sees patients'';
11 (IV) by striking the period and
12 inserting ''; and''; and
13 (V) by adding at the end the fol-
14 lowing:
15 ''(ii) with respect to each such pro-
16 vider or facility—
17 ''(I) whether such provider or fa-
18 cility is accepting new patients;
19 ''(II) the languages spoken and
20 the availability of language translators
21 for specified languages at each health
22 care facility listed in the directory;
23 ''(III) whether the provider or fa-
24 cility offers medication-assisted treat-
25 ment for opioid use disorder;

1 "(IV) the State license number;
2 "(V) the national provider identi-
3 fier;
4 "(VI) the age groups served by
5 the provider or facility, such as pedi-
6 atric, adolescent, adult, or geriatric
7 populations;
8 "(VII) whether such provider or
9 facility offers in-person services, tele-
10 health services, or both;
11 "(VIII) the cost-sharing tier, if
12 applicable; and
13 "(IX) health insurance plans ac-
14 cepted (including the plan identifier
15 and type of plan).
16 "(B) GHOST NETWORK.—The term 'ghost
17 network' means a group health plan or group
18 health insurance coverage for which the pro-
19 vider directory information describing the net-
20 work of such plan or coverage—
21 "(i) includes inaccurate contact infor-
22 mation with respect to a substantial share
23 of included listings and providers who are
24 part of the network;

1 "(ii) includes a substantial number of
2 providers and facilities (as specified by the
3 Secretary, in coordination with the Sec-
4 retary of Health and Human Services and
5 the Secretary of the Treasury) in a spe-
6 cialty who are not accepting new patients
7 within a time period specified by such sec-
8 retaries;
9 "(iii) includes a substantial number of
10 providers and facilities that are not part of
11 the network; or
12 "(iv) omits a substantial number of
13 providers and facilities that are part of the
14 network."; and
15 (B) in subsection (b)—
16 (i) in paragraph (1), by striking "and
17 if either of the criteria described in para-
18 graph (2) applies with respect to such par-
19 ticipant, beneficiary, or enrollee and item
20 or service"; and
21 (ii) by striking paragraph (2) and in-
22 serting the following:
23 "(2) RECONCILIATION REQUIREMENT.—If a
24 nonparticipating provider was listed as a partici-
25 pating provider in the posted provider directory

1 database, the group health plan or health insurance
2 issuer shall, not later than 30 days after receiving
3 the request for payment, notify the participant, ben-
4 eficiary, or enrollee, in plain language, that the par-
5 ticipant, beneficiary, or enrollee may be eligible for
6 a refund from the group health plan or health insur-
7 ance issuer if such participant, beneficiary, or en-
8 rollee paid the out of network cost-sharing and did
9 not receive a refund under section 2799B–9(b) of
10 the Public Health Service Act (42 U.S.C. 300gg–
11 139).''.

12 (2) CIVIL MONETARY PENALTIES FOR VIOLA-
13 TIONS.—

14 (A) CIVIL MONETARY PENALTIES RELAT-
15 ING TO PROVIDER DIRECTORY REQUIRE-
16 MENTS.—Section 502(c)(10) of the Employee
17 Retirement Income Security Act of 1974 (29
18 U.S.C. 1132(c)(10)(A)) is amended—

19 (i) in the heading, by striking ''USE
20 OF GENETIC INFORMATION'' and inserting
21 ''USE OF GENETIC INFORMATION AND PRO-
22 VIDER DIRECTORY REQUIREMENTS''; and

23 (ii) in subparagraph (A)—

24 (I) by inserting ''plan adminis-
25 trator of a group health plan (includ-

1 ing a third party administrator),''
2 after ''plan sponsor of a group health
3 plan,'';
4 (II) by inserting '', adminis-
5 trator,'' after ''such sponsor''; and
6 (III) by striking ''for any failure''
7 and all that follows through ''in con-
8 nection with the plan.'' and inserting
9 ''for any failure by such plan sponsor,
10 plan administrator, or health insur-
11 ance issuer, in connection with the
12 plan—
13 ''(i) to meet the requirements of sub-
14 section (a)(1)(F), (b)(3), (c), or (d) of sec-
15 tion 702 or section 701 or 702(b)(1) with
16 respect to genetic information; or
17 ''(ii) to meet the requirements of sec-
18 tion 720 with respect to provider directory
19 information.''.
20 (B) EXCEPTION TO THE GENERAL PROHI-
21 BITION ON ENFORCEMENT.—Section 502 of
22 such Act (29 U.S.C. 1132) is amended—
23 (i) in subsection (a)(6), by striking
24 ''or (9)'' and inserting ''(9), or (10)''; and
25 (ii) in subsection (b)(3)—

1 (I) by striking "subsections
2 (c)(9) and (a)(6)" and inserting "sub-
3 sections (c)(9), (c)(10), and (a)(6)";
4 (II) by striking "under sub-
5 section (c)(9))" and inserting "under
6 subsections (c)(9) and (c)(10)), and
7 except with respect to enforcement by
8 the Secretary of section 720"; and
9 (III) by striking "706(a)(1)" and
10 inserting "733(a)(1)".
11 (c) IRC.—Section 9820 of the Internal Revenue Code
12 of 1986 is amended—
13 (1) in subsection (a)—
14 (A) in paragraph (1)—
15 (i) by striking "For plan years begin-
16 ning on or after January 1, 2022, each"
17 and inserting "Each";
18 (ii) in subparagraph (C), by striking
19 "; and" and inserting a semicolon;
20 (iii) in subparagraph (D), by striking
21 the period and inserting "; and"; and
22 (iv) by adding at the end the fol-
23 lowing:
24 "(E) ensure that any directory, including
25 the database described in subparagraph (C),

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

9 (B) in paragraph (3)—

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

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

22 (C) in paragraph (4)—

23 (i) in subparagraph (A), by striking
24 ''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, as appropriate, the State
12 consumer assistance program or ombudsman or
13 the Employee Benefits Security Administration
14 for more information.";
15 (D) in paragraph (5), by adding at the end
16 the following: "Such information shall include a
17 statement, in plain language, concerning the
18 rights of the participant, beneficiary, or enrollee
19 to cost-sharing protections pursuant to sub-
20 section (b) in the event of reliance on inac-
21 curate provider directory information supplied
22 by a group health plan, and contact information
23 for, as appropriate, the State consumer assist-
24 ance program or ombudsman or the Employee

1 Benefits Security Administration for more in-
2 formation.'';
3 (E) by redesignating paragraphs (6) and
4 (7) as paragraphs (8) and (9), respectively;
5 (F) by inserting after paragraph (5) the
6 following:
7 ''(6) PROTECTING PARTICIPANTS, BENE-
8 FICIARIES, AND ENROLLEES FROM GHOST NET-
9 WORKS.—The Secretary, in collaboration with the
10 Secretary of Labor and the Secretary of Health and
11 Human Services, shall—
12 ''(A) not later than 4 years after the date
13 of enactment of the Behavioral Health Network
14 and Directory Improvement Act, issue final reg-
15 ulations further defining the term 'ghost net-
16 work' (as defined in paragraph (8)); and
17 ''(B) not later than 4 years after the date
18 of enactment of the Behavioral Health Network
19 and Directory Improvement Act, issue final reg-
20 ulations, subregulatory guidance, or program
21 instruction on how to assess ghost networks in
22 health plan directories including reasonable as-
23 sumptions related to statistics and research
24 methods.

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

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

"(B) PROVIDER DIRECTORY INDEPENDENT AUDIT REQUIREMENTS.—

1 "(i) IN GENERAL.—Beginning not
2 later than 3 years after the date of enact-
3 ment of the Behavioral Health Network
4 and Directory Improvement Act, each
5 group health plan shall conduct an annual
6 directory audit, through an independent
7 entity not associated with the health plan,
8 that considers the factors described in
9 clause (ii)(I)(aa) and follows the guidelines
10 developed under clause (ii)(I)(bb).
11 "(ii) INFORMATION TO BE IN-
12 CLUDED.—
13 "(I) IN GENERAL.—For purposes
14 of carrying out the audits under this
15 subparagraph, the Secretary shall—
16 "(aa) develop a list of infor-
17 mation required to be included;
18 and
19 "(bb) provide guidelines for
20 carrying out such audits, for use
21 by group health plans, on—
22 "(AA) the reasonable
23 assumptions and research
24 methods to select a reason-
25 able sample in order to as-

1 sess provider directory information accuracy; and
3 "(BB) determining the criteria of an eligible auditor.
6 "(II) CONTENTS.—The information listed under subclause (I)(aa) shall include the following:
9 "(aa) The proportion of directory listings of the plan with inaccurate information, including incorrect contact information, as specified by the Secretary, during the audit period.
15 "(bb) The number of in-network items or services paid on behalf of participants, beneficiaries, and enrollees in the plan to providers or facilities who have a network provider contract with the health plan and were not listed in the directory of the health plan for the audit period.
24 "(cc) The resources of the plan to help participants, bene-

1 ficiaries, and enrollees locate an
2 accurately listed in-network pro-
3 vider who is accepting new pa-
4 tients.

5 "(dd) The proportion of par-
6 ticipants, beneficiaries, and en-
7 rollees using out-of-network pro-
8 viders for mental health and sub-
9 stance use disorder services, and
10 the proportion of participants,
11 beneficiaries, and enrollees using
12 out-of-network providers and fa-
13 cilities for medical and surgical
14 services.

15 "(ee) Documentation that
16 the plan verifies the accuracy of
17 the provider directory informa-
18 tion every 90 days.

19 "(ff) Other factors as deter-
20 mined by the Secretary.

21 "(iii) STANDARDS FOR REPORTING.—
22 An audit under this subparagraph is com-
23 plete if all of the following conditions are
24 met:

1 "(I) The audit report includes
2 the following:
3 "(aa) A statement by the
4 independent auditor that, to the
5 best of the auditor's knowledge,
6 the report is complete and accu-
7 rate, and that reasonable as-
8 sumptions related to statistics
9 and research methods have been
10 complied with.
11 "(bb) A statement explain-
12 ing the assumptions, statistics,
13 and methods used to select the
14 sample and assess provider direc-
15 tory information accuracy.
16 "(cc) Such other require-
17 ments as the Secretary deter-
18 mines necessary.
19 "(II) The group health plan
20 makes the independent audit available
21 on a public website.
22 "(iv) RULEMAKING.—The Secretary,
23 the Secretary of Labor, and the Secretary
24 of Health and Human Services shall issue
25 interim final regulations (without prior no-

1 tice and comment as generally required
2 under section 553 of title 5, United States
3 Code) concerning the national standards
4 for conducting audits under this subpara-
5 graph, not later than 2 years after the
6 date of enactment of the Behavioral
7 Health Network and Directory Improve-
8 ment Act.

9 "(C) AUDITS BY THE SECRETARY.—

10 "(i) IN GENERAL.—Beginning not
11 later than the fourth plan year after the
12 date of enactment of the Behavioral
13 Health Network and Directory Improve-
14 ment Act, the Secretary shall conduct an-
15 nual audits to ensure compliance with the
16 auditing requirements under subparagraph
17 (B).

18 "(ii) SELECTION OF PLANS.—The
19 Secretary, the Secretary of Labor, and the
20 Secretary of Health and Human Services
21 (referred to in this clause as the 'Secre-
22 taries'), jointly, shall conduct annual au-
23 dits of the submissions under subpara-
24 graph (B) of a total of not fewer than 10
25 group health plans, as determined by the

1 Secretaries, that are the subjects of complaints about ghost networks or other complaints, or that are randomly selected by the Secretaries.''; and

5 (G) in paragraph (8), as so redesignated—

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

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

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

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

17 ''(i) the name, address where the provider regularly sees patients'';

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

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

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

24 ''(I) whether such provider or facility 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;
18 "(VIII) the cost-sharing tier, if
19 applicable; and
20 "(IX) health insurance plans ac-
21 cepted (including the plan identifier
22 and type of plan).
23 "(B) GHOST NETWORK.—The term 'ghost
24 network' means a group health plan for which

1 the provider directory information describing
2 the network of such plan—
3 "(i) includes inaccurate contact infor-
4 mation with respect to a substantial share
5 of included listings and providers who are
6 part of the network;
7 "(ii) includes a substantial number of
8 providers and facilities (as specified by the
9 Secretary, in coordination with the Sec-
10 retary of Labor and the Secretary of
11 Health and Human Services) in a specialty
12 who are not accepting new patients within
13 a time period specified by such secretaries;
14 "(iii) includes a substantial number of
15 providers and facilities that are not part of
16 the network; or
17 "(iv) omits a substantial number of
18 providers and facilities that are part of the
19 network."; and
20 (2) in subsection (b)—
21 (A) in paragraph (1), by striking "and if
22 either of the criteria described in paragraph (2)
23 applies with respect to such participant, bene-
24 ficiary, or enrollee and item or service"; and

1 (B) by striking paragraph (2) and insert-
2 ing the following:
3 "(2) RECONCILIATION REQUIREMENT.—If a
4 nonparticipating provider was listed as a partici-
5 pating provider in the posted provider directory
6 database, the group health plan shall, not later than
7 30 days after receiving the request for payment, no-
8 tify the participant, beneficiary, or enrollee, in plain
9 language, that the participant, beneficiary, or en-
10 rollee may be eligible for a refund from the group
11 health plan if such participant, beneficiary, or en-
12 rollee paid the out of network cost-sharing and did
13 not receive a refund under section 2799B–9(b) of
14 the Public Health Service Act (42 U.S.C. 300gg–
15 139).".
16 (d) EFFECTIVE DATE.—The amendments made by
17 subsections (a), (b), and (c) shall apply with respect to
18 group health plans, or any health insurance issuer offering
19 health insurance coverage in connection with such plan,
20 for plan years beginning after the date that is 1 year after
21 the date of enactment of this Act.

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

4 Section 2799B–9 of the Public Health Service Act
5 (42 U.S.C. 300gg–139) is amended—
6 (1) in subsection (a)—
7 (A) in paragraph (3), by striking ''; and''
8 and inserting a semicolon;
9 (B) by redesignating paragraph (4) as
10 paragraph (6); and
11 (C) by inserting after paragraph (3) the
12 following:
13 ''(4) subject to paragraph (5), when a provider
14 or facility that is not accepting new patients deter-
15 mines that it has the ability to accept new patients,
16 within 5 business days of such determination;
17 ''(5) when a solo practitioner or small provider,
18 as determined by the Secretary, determines that it
19 has the ability to accept new patients, within 10
20 business days of such determination; and''; and
21 (2) by amending subsection (d) to read as fol-
22 lows:
23 ''(d) DEFINITION.—For purposes of this section, the
24 term 'provider directory information' includes—
25 ''(1) the name, address, specialty, telephone
26 number, and digital contact information of each in-

1 dividual health care provider contracted to partici-
2 pate in any of the networks of the group health plan
3 or health insurance coverage involved;
4 ‘‘(2) the name, address, specialty, telephone
5 number, and digital contact information of each
6 medical group, clinic, or facility contracted to par-
7 ticipate in any of the networks of the group health
8 plan or health insurance coverage involved; and
9 ‘‘(3) with respect to each such provider, medical
10 group, clinic, or facility—
11 ‘‘(A) whether such provider, medical group,
12 clinic, or facility is accepting new patients;
13 ‘‘(B) the languages spoken and the avail-
14 ability of language translators for specified lan-
15 guages at each provider, medical group, clinic,
16 or facility listed in the directory;
17 ‘‘(C) whether the provider, medical group,
18 clinic, or facility offers medication-assisted
19 treatment for opioid use disorder;
20 ‘‘(D) the State license number;
21 ‘‘(E) the national provider identifier;
22 ‘‘(F) the age groups served by such pro-
23 vider, group, clinic, or facility, such as pedi-
24 atric, adolescent, adult, or geriatric populations;

1 “(G) whether such provider, group, clinic,
2 or facility offers in-person services, telehealth
3 services, or both; and
4 “(H) the cost-sharing tier, if applicable.”.

5 **SEC. 4. STRENGTHENING MENTAL HEALTH AND SUB-**
6 **STANCE USE DISORDER PARITY REQUIRE-**
7 **MENTS.**

8 (a) PHSA.—
9 (1) NETWORK ADEQUACY REQUIREMENTS.—
10 Section 2726(a) of the Public Health Service Act
11 (42 U.S.C. 300gg–26(a)) is amended by adding at
12 the end the following:
13 “(9) NETWORK ADEQUACY REQUIREMENTS.—
14 “(A) IN GENERAL.—The Secretary, the
15 Secretary of Labor, and the Secretary of the
16 Treasury shall issue regulations establishing na-
17 tional quantitative standards for mental health
18 and substance use disorder network adequacy.
19 Such standards shall consider—
20 “(i) the ratio of in-network mental
21 health providers who submitted claims
22 under the plan or coverage in the previous
23 plan year, separated by professional type
24 of mental health provider, to participants,

1 beneficiaries, and enrollees in a group
2 health plan or health insurance coverage;
3 "(ii) the ratio of in-network substance
4 use disorder providers who submitted
5 claims under the plan or coverage in the
6 previous plan year, separated by profes-
7 sional type of substance use disorder pro-
8 vider, to participants, beneficiaries, and en-
9 rollees in a group health plan or health in-
10 surance coverage;
11 "(iii) separately, for mental health
12 services and substance use disorder serv-
13 ices—
14 "(I) geographic accessibility of
15 providers;
16 "(II) geographic variation and
17 population dispersion;
18 "(III) waiting times for appoint-
19 ments with participating providers;
20 "(IV) hours of operation for par-
21 ticipating providers;
22 "(V) the ability of the network to
23 meet the needs of participants, bene-
24 ficiaries, and enrollees, including low-
25 income individuals, individuals who

1 are members of a racial or ethnic minority, individuals who live in a health professional shortage area, children and adults with serious, chronic, and complex health conditions, individuals with physical or mental disabilities or substance use disorders, pediatric populations, and individuals with limited English proficiency;

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

15 ‘‘(VII) the percentage of in-network providers who have submitted a claim for payment during a previous 6-month period, as determined by the Secretary, the Secretary of Labor, and the Secretary of the Treasury; and

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

25 ‘‘(B) TIMING.—

1 "(i) ISSUANCE.—The Secretary, the
2 Secretary of Labor, and the Secretary of
3 the Treasury shall—
4 "(I) issue proposed regulations
5 required under subparagraph (A) not
6 later than 2 years after the date of
7 enactment of the Behavioral Health
8 Network and Directory Improvement
9 Act; and
10 "(II) issue final regulations
11 under subparagraph (A) not later
12 than 1 year thereafter.
13 "(ii) EFFECTIVE DATE.—The regula-
14 tions promulgated under this paragraph
15 shall take effect in the first plan year that
16 begins after the date on which such final
17 regulations are issued.
18 "(C) AUDITS.—The Secretary, the Sec-
19 retary of Labor, and the Secretary of the
20 Treasury (referred to in this subparagraph as
21 the 'Secretaries'), jointly, shall conduct annual,
22 targeted audits of not fewer than 10 group
23 health plans and health insurance issuers offer-
24 ing group or individual health insurance cov-
25 erage that the Secretaries select based upon the

1 number of complaints about mental health and
2 substance use disorder network adequacy to en-
3 sure compliance with the requirements of this
4 paragraph. Such audits shall begin not earlier
5 than one year after the final regulations imple-
6 menting this paragraph begin to apply to group
7 health plans and health insurance issuers.''.
8 (2) DEFINITIONS.—Paragraphs (4) and (5) of
9 section 2726(e) of the Public Health Service Act (42
10 U.S.C. 300gg–26(e)) are amended to read as fol-
11 lows:
12 ''(4) MENTAL HEALTH BENEFITS.—The term
13 'mental health benefits' means benefits with respect
14 to services related to a mental health condition, de-
15 fined consistently with generally recognized inde-
16 pendent standards of current medical practice, such
17 as the Diagnostic and Statistical Manual of Mental
18 Disorders of the American Psychiatric Association.
19 ''(5) SUBSTANCE USE DISORDER BENEFITS.—
20 The term 'substance use disorder benefits' means
21 benefits with respect to services related to a sub-
22 stance use disorder, defined consistently with gen-
23 erally recognized independent standards of current
24 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 2726(a) of the Public Health
5 Service Act (42 U.S.C. 300gg–26(a)), as amended
6 by paragraph (1), is further amended by adding at
7 the end the following:

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 Labor, and
14 the Secretary of the Treasury shall issue regu-
15 lations on a standard for parity in reimburse-
16 ment rates for mental health or substance use
17 disorder benefits and medical and surgical bene-
18 fits, based on a comparative analysis conducted
19 by such Secretaries using data submitted by
20 group health plans and health insurance
21 issuers, provider associations, and other experts
22 related to the cost of care delivery for mental
23 health and substance use disorder benefits.

24 ''(B) REQUESTS FOR DATA.—Group health
25 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), in a manner that avoids unnecessary duplication.

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

(b) ERISA.—

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

"(9) NETWORK ADEQUACY REQUIREMENTS.—

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

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

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

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

"(I) geographic accessibility of providers;

"(II) geographic variation and population dispersion;

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

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 a previous
24 6-month period, as determined by the
25 Secretary, the Secretary of Health

1 and Human Services, and the Sec-
2 retary of the Treasury; 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 (referred to in this
4 subparagraph as the 'Secretaries'), jointly, shall
5 conduct annual, targeted audits of not fewer
6 than 10 group health plans and health insur-
7 ance issuers offering group health insurance
8 coverage that the Secretaries select based upon
9 the number of complaints about mental health
10 and substance use disorder network adequacy
11 to ensure compliance with the requirements of
12 this paragraph. Such audits shall begin not ear-
13 lier than one year after the final regulations im-
14 plementing this paragraph begin to apply to
15 group health plans and health insurance
16 issuers.".
17 (2) DEFINITIONS.—Paragraphs (4) and (5) of
18 section 712(e) of the Employee Retirement Income
19 Security Act of 1974 (29 U.S.C. 1185a(e)) are
20 amended to read as follows:
21 "(4) MENTAL HEALTH BENEFITS.—The term
22 'mental health benefits' means benefits with respect
23 to services related to a mental health condition, de-
24 fined consistently with generally recognized inde-
25 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), in a manner that avoids un-
15 necessary duplication.

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

22 (c) IRC.—

23 (1) NETWORK ADEQUACY REQUIREMENTS.—
24 Section 9812(a) of the Internal Revenue Code of
25 1986 is amended by adding at the end the following:

1 ‘‘(9) NETWORK ADEQUACY REQUIREMENTS.—
2 ‘‘(A) IN GENERAL.—The Secretary, the
3 Secretary of Health and Human Services, and
4 the Secretary of Labor shall issue regulations
5 establishing national quantitative standards for
6 mental health and substance use disorder net-
7 work adequacy. Such standards shall consider—
8 ‘‘(i) the ratio of in-network mental
9 health providers who submitted claims
10 under the plan in the previous plan year,
11 separated by professional type of mental
12 health provider, to participants, bene-
13 ficiaries, and enrollees in a group health
14 plan;
15 ‘‘(ii) the ratio of in-network substance
16 use disorder providers who submitted
17 claims under the plan in the previous plan
18 year, separated by professional type of sub-
19 stance use disorder provider, to partici-
20 pants, beneficiaries, and enrollees in a
21 group health plan;
22 ‘‘(iii) separately, for mental health
23 services and substance use disorder serv-
24 ices—

1 "(I) geographic accessibility of
2 providers;
3 "(II) geographic variation and
4 population dispersion;
5 "(III) waiting times for appoint-
6 ments with participating providers;
7 "(IV) hours of operation for par-
8 ticipating providers;
9 "(V) the ability of the network to
10 meet the needs of participants, bene-
11 ficiaries, and enrollees, including low-
12 income individuals, individuals who
13 are members of a racial or ethnic mi-
14 nority, individuals who live in a health
15 professional shortage area, children
16 and adults with serious, chronic, and
17 complex health conditions, individuals
18 with physical or mental disabilities or
19 substance use disorders, pediatric
20 populations, and individuals with lim-
21 ited English proficiency;
22 "(VI) the availability of in-person
23 services, telehealth services, and hy-
24 brid services to serve the needs of par-

1 ticipants, beneficiaries, and enrollees;
2 and
3 "(VII) the percentage of in-net-
4 work providers who have submitted a
5 claim for payment during a previous
6 6-month period, as determined by the
7 Secretary, the Secretary of Health
8 and Human Services, and the Sec-
9 retary of Labor; and
10 "(iv) other standards as determined
11 by the Secretary, the Secretary of Health
12 and Human Services, and the Secretary of
13 Labor.
14 "(B) TIMING.—
15 "(i) ISSUANCE.—The Secretary, the
16 Secretary of Health and Human Services,
17 and the Secretary of Labor shall—
18 "(I) issue proposed regulations
19 required under subparagraph (A) not
20 later than 2 years after the date of
21 enactment of the Behavioral Health
22 Network and Directory Improvement
23 Act; and

1 "(II) issue final regulations
2 under subparagraph (A) not later
3 than 1 year thereafter.
4 "(ii) EFFECTIVE DATE.—The regula-
5 tions promulgated under this paragraph
6 shall take effect in the first plan year that
7 begins after the date on which such final
8 regulations are issued.
9 "(C) AUDITS.—The Secretary, the Sec-
10 retary of Health and Human Services, and the
11 Secretary of Labor (referred to in this subpara-
12 graph as the 'Secretaries'), jointly, shall con-
13 duct annual, targeted audits of not fewer than
14 10 group health plans that the Secretaries se-
15 lect based upon the number of complaints about
16 mental health and substance use disorder net-
17 work adequacy to ensure compliance with the
18 requirements of this paragraph. Such audits
19 shall begin not earlier than one year after the
20 final regulations implementing this paragraph
21 begin to apply to group health plans.".
22 (2) DEFINITIONS.—Paragraphs (4) and (5) of
23 section 9812(e) of the Internal Revenue Code of
24 1986 are amended to read as follows:

1 "(4) MENTAL HEALTH BENEFITS.—The term
2 'mental health benefits' means benefits with respect
3 to services related to a mental health condition, de-
4 fined consistently with generally recognized inde-
5 pendent standards of current medical practice, such
6 as the Diagnostic and Statistical Manual of Mental
7 Disorders of the American Psychiatric Association.
8 "(5) SUBSTANCE USE DISORDER BENEFITS.—
9 The term 'substance use disorder benefits' means
10 benefits with respect to services related to a sub-
11 stance use disorder, defined consistently with gen-
12 erally recognized independent standards of current
13 medical practice, such as the Diagnostic and Statis-
14 tical Manual of Mental Disorders of the American
15 Psychiatric Association.".
16 (3) STANDARDS FOR PARITY IN REIMBURSE-
17 MENT RATES.—Section 9812(a) of the Internal Rev-
18 enue Code of 1986, as amended by paragraph (1),
19 is further amended by adding at the end the fol-
20 lowing:
21 "(10) STANDARDS FOR PARITY IN REIMBURSE-
22 MENT RATES.—
23 "(A) IN GENERAL.—Not later than 2 years
24 after the date of enactment of the Behavioral
25 Health Network and Directory Improvement

1 Act, the Secretary, the Secretary of Health and
2 Human Services, and the Secretary of Labor
3 shall issue regulations on a standard for parity
4 in reimbursement rates for mental health or
5 substance use disorder benefits and medical and
6 surgical benefits, based on a comparative anal-
7 ysis conducted by such Secretaries using data
8 submitted by group health plans, provider asso-
9 ciations, and other experts related to the cost of
10 care delivery for mental health and substance
11 use disorder benefits.

12 ''(B) REQUESTS FOR DATA.—Group health
13 plans shall comply with any request for data
14 issued by the Secretary, the Secretary of Health
15 and Human Services, and the Secretary of
16 Labor for purposes of developing the standards
17 under subparagraph (A), in a manner that
18 avoids unnecessary duplication.

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

1 **SEC. 5. STATE AND TRIBAL OMBUDSMAN PROGRAMS RE-**
2 **LATING TO MENTAL HEALTH AND SUB-**
3 **STANCE USE DISORDER PARITY.**

4 Part C of title XXVII of the Public Health Service
5 Act (42 U.S.C. 300gg–91 et seq.) is amended—
6 (1) by redesignating section 2794 (42 U.S.C.
7 300gg–95) (regarding uniform fraud and abuse re-
8 ferral format), as added by section 6603 of the Pa-
9 tient Protection and Affordable Care Act (Public
10 Law 111–148), as section 2795; and
11 (2) by adding at the end the following:

12 **"SEC. 2796. STATE AND TRIBAL OMBUDSMAN PROGRAMS**
13 **RELATING TO MENTAL HEALTH AND SUB-**
14 **STANCE USE DISORDER PARITY.**

15 "(a) IN GENERAL.—The Secretary shall make grants
16 to eligible entities, designated by a State, Indian Tribe,
17 or Tribal organization, as described in subsection (b), for
18 the purpose of—
19 "(1) establishing or supporting State and Trib-
20 al mental health and substance use disorder parity
21 ombudsman programs to—
22 "(A) educate consumers about the mental
23 health and substance use disorder coverage in
24 individual plans, group health plans, self-in-
25 sured plans, and State Medicaid managed care
26 plans;

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

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

14 "(D) identify, investigate, and help resolve
15 complaints related to mental health and sub-
16 stance use disorder coverage (including poten-
17 tial violations of the mental health and sub-
18 stance use disorder parity laws) on behalf of
19 consumers;

20 "(E) maintain a toll-free hotline and
21 website for consumers;

22 "(F) collect, track, and quantify problems
23 and inquiries encountered by consumers; and

24 "(G) other activities as defined by the Sec-
25 retary; and

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

6 "(b) ELIGIBILITY.—To be eligible to receive a grant
7 under this section, a State, Indian Tribe, or Tribal organi-
8 zation shall designate an ombudsman or consumer assist-
9 ance program or other independent entity that—

10 "(1) has specialized knowledge of mental health
11 conditions and substance use disorders and experi-
12 ence resolving inquiries and complaints; and

13 "(2) directly, or in coordination with depart-
14 ments of insurance, and consumer assistance organi-
15 zations, receives and responds to inquiries and com-
16 plaints concerning access to mental health and sub-
17 stance use disorder services.

18 "(c) CRITERIA.—A State, Indian Tribe, or Tribal or-
19 ganization that receives a grant under this section shall
20 comply with criteria established by the Secretary for car-
21 rying out activities under such grant.

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

24 "(1) collect and report data to the Secretary,
25 State legislature, and relevant State agencies, in-

1 cluding the departments of insurance and the State
2 attorney general, on the numbers and types of prob-
3 lems and inquiries encountered by individuals with
4 respect to access to behavioral health services; and
5 ''(2) report to the Secretary on how identified
6 problems were addressed, including through prom-
7 ising practices related to responding to mental
8 health and substance use disorder coverage issues,
9 including appeals and education.
10 ''(e) REPORT TO CONGRESS.—Not later than 4 years
11 after the date of the enactment of the Behavioral Health
12 Network and Directory Improvement Act, the Secretary
13 shall submit to Congress a report on the data collected
14 under subsection.
15 ''(f) DEFINITIONS.—In this section, the terms 'In-
16 dian Tribe' and 'Tribal organization' have the meanings
17 given such terms in section 4 of the Indian Self-Deter-
18 mination and Education Assistance Act.
19 ''(g) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this section, there are authorized to be appro-
21 priated $20,000,000 for fiscal year 2025 and $10,000,000
22 for fiscal year 2026 and each fiscal year thereafter.''.
23 **SEC. 6. REPORT TO CONGRESS.**
24 (a) IN GENERAL.—Not later than 6 years after the
25 date of enactment of this Act and every 2 years for the

1 next 10 years, the Secretary of Health and Human Serv-
2 ices, the Secretary of Labor, and the Secretary of the
3 Treasury (collectively referred to in this section as the
4 "Secretaries") shall jointly submit to Congress and make
5 publicly available a report to assess the prevalence of ghost
6 networks and the adequacy of mental health and sub-
7 stance use disorder networks, in accordance with section
8 2726(a)(9) of the Public Health Service Act, section
9 712(a)(9) of the Employee Retirement Income Security
10 Act of 1974, and section 9812(a)(9) of the Internal Rev-
11 enue Code of 1986, as amended by section 4. Such report
12 shall include the following:

13 (1) Aggregate information about group health
14 plans and health insurance issuers determined by
15 the Secretaries to be out of compliance with the pro-
16 vider directory requirements under section 2799A–5
17 of the Public Health Service Act, section 720 of the
18 Employee Retirement Income Security Act of 1974,
19 and section 9820 of the Internal Revenue Code of
20 1986, as amended by section 2.

21 (2) Aggregate information about group health
22 plans and health insurance issuers determined by
23 the Secretaries to be out of compliance with the re-
24 quirements for parity in mental health and sub-
25 stance use disorder benefits under section 2726 of

1 the Public Health Service Act (42 U.S.C. 300gg–
2 26), section 712 of the Employee Retirement Income
3 Security Act of 1974 (29 U.S.C. 1185a), and section
4 9812 of the Internal Revenue Code of 1986, as
5 amended by section 4.

6 (3) A summary of findings through audits, in
7 the aggregate, under section 2799A–5(a)(7)(C) of
8 the Public Health Service Act, section 720(a)(7)(C)
9 of the Employee Retirement Income Security Act of
10 1974, and section 9820(a)(7)(C) of the Internal
11 Revenue Code of 1986, as amended by section 2, in-
12 cluding—

13 (A) the accuracy of provider directory in-
14 formation, sectioned out by accuracy of the pro-
15 vider's name, address, specialty, telephone num-
16 ber, digital contact information, whether the
17 providers are accepting new patients, in-net-
18 work status, linguistic- and cultural-com-
19 petency, and availability of medications for
20 opioid use disorder;

21 (B) the number of plans and individuals
22 enrolled in a group health plan or group or in-
23 dividual health insurance coverage that offers a
24 mental health and substance use disorder net-
25 work that meets the network adequacy stand-

ards under, as applicable, section 2799A–5 of the Public Health Service Act, section 720 of the Employee Retirement Income Security Act of 1974, or section 9820 of the Internal Revenue Code of 1986, as amended by section 2; and

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

(4) A comparative analysis of in-network and out-of-network reimbursement rates for mental health and substance use disorder services compared to medical and surgical services by group health plans and health insurance issuers.

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

SEC. 7. AUTHORIZATION OF APPROPRIATIONS.

(a) ADMINISTRATIVE FUNCTIONS.—To carry out sections 4, 5, and 6, including the amendments made by such sections, there are authorized to be appropriated to the Secretary of Health and Human Services, the Secretary

of Labor, and the Secretary of the Treasury such sums as may be necessary.

(b) PROTECTING PATIENTS AND IMPROVING THE ACCURACY OF PROVIDER DIRECTORY INFORMATION.—To carry out section 2, including the amendments made by such section, in addition to amounts otherwise made available for such purposes, there are authorized to be appropriated—

(1) to the Secretary of Health and Human Services, for purposes of carrying out the amendments made by subsection (a) of such section—

(A) $15,200,000 for each of fiscal years 2025 and 2026;

(B) $17,000,000 for fiscal year 2027; and

(C) $10,000,000 for fiscal year 2028 and each fiscal year thereafter; and

(2) to the Secretary of Labor, for purposes of carrying out the amendments made by subsection (b) of such section, $22,000,000 for fiscal year 2025 and each fiscal year thereafter.

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