116TH CONGRESS
2D SESSION

H. R. 7539

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

IN THE HOUSE OF REPRESENTATIVES

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

July 9, 2020

A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Strengthening Behavioral Health Parity Act”.

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

(a) PHSA.—
(1) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following new part:

“PART D—ADDITIONAL COVERAGE PROVISIONS

“SEC. 2799A–1. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.

“(a) IN GENERAL.—

“(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

“(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.

“(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the ‘applicable
lifetime limit’), the plan or coverage shall ei-
ther—

“(i) apply the applicable lifetime limit
both to the medical and surgical benefits to
which it otherwise would apply and to
mental health and substance use disorder
benefits and not distinguish in the applica-
tion of such limit between such medical
and surgical benefits and mental health
and substance use disorder benefits; or

“(ii) not include any aggregate life-
time limit on mental health or substance
use disorder benefits that is less than the
applicable lifetime limit.

“(C) RULE IN CASE OF DIFFERENT LIM-
ITS.—In the case of a plan or coverage that is
not described in subparagraph (A) or (B) and
that includes no or different aggregate lifetime
limits on different categories of medical and
surgical benefits, the Secretary shall establish
rules under which subparagraph (B) is applied
to such plan or coverage with respect to mental
health and substance use disorder benefits by
substituting for the applicable lifetime limit an
average aggregate lifetime limit that is com-
puted taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

“(2) **ANNUAL LIMITS.**—In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits—

“(A) **NO ANNUAL LIMIT.**—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health or substance use disorder benefits.

“(B) **ANNUAL LIMIT.**—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the ‘applicable annual limit’), the plan or coverage shall either—

“(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical...
and surgical benefits and mental health
and substance use disorder benefits; or
“(ii) not include any annual limit on
mental health or substance use disorder
benefits that is less than the applicable an-
nual limit.
“(C) Rule in case of different lim-
its.—In the case of a plan or coverage that is
not described in subparagraph (A) or (B) and
that includes no or different annual limits on
different categories of medical and surgical ben-
efits, the Secretary shall establish rules under
which subparagraph (B) is applied to such plan
or coverage with respect to mental health and
substance use disorder benefits by substituting
for the applicable annual limit an average an-
nual limit that is computed taking into account
the weighted average of the annual limits appli-
cable to such categories.
“(3) Financial requirements and treat-
ment limitations.—
“(A) In general.—In the case of a group
health plan or a health insurance issuer offering
group or individual health insurance coverage
that provides both medical and surgical benefits
and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“(B) DEFINITIONS.—In this paragraph:
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“(i) **FINANCIAL REQUIREMENT.**—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

“(ii) **PREDOMINANT.**—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) **TREATMENT LIMITATION.**—The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

“(4) **AVAILABILITY OF PLAN INFORMATION.**—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance
with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

“(5) Out-of-network providers.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

“(6) Compliance program guidance document.—

“(A) In general.—Not later than 12 months after the date of enactment of the
Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled ‘Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance’.

“(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

“(i) IN GENERAL.—The compliance program guidance document required
under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and non-compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, based on investigations of violations of such sections, including—

“(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

“(II) descriptions of the violations uncovered during the course of such investigations.

“(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully
explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

“(iii) Access to additional information regarding compliance.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

“(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable; and
“(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of non-quantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, in
relation to nonquantitative treatment limitations on medical and surgical benefits.

“(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(7) ADDITIONAL GUIDANCE.—

“(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary
of Labor, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(B) DISCLOSURE.—

“(i) GUIDANCE FOR PLANS AND ISSUERS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).
“(ii) DOCUMENTS FOR PARTICIPANTS,

beneficiaries, contracting providers,

or authorized representatives.—The
guidance issued under this paragraph shall
include clarifying information and illus-

trative examples of methods that group
health plans and health insurance issuers
offering group or individual health insur-

ance coverage may use to provide any par-
ticipant, beneficiary, contracting provider,
or authorized representative, as applicable,
with documents containing information
that the health plans or issuers are re-

quired to disclose to participants, bene-

ficiaries, contracting providers, or author-
ized representatives to ensure compliance
with this section, section 712 of the Em-

ployee Retirement Income Security Act of
1974, or section 9812 of the Internal Rev-

enue Code of 1986, as applicable, compli-

ance with any regulation issued pursuant
to such respective section, or compliance
with any other applicable law or regula-
tion. Such guidance shall include informa-
tion that is comparative in nature with re-
spect to—

“(I) nonquantitative treatment 
limitations for both medical and sur-
gical benefits and mental health and 
substance use disorder benefits;

“(II) the processes, strategies, 
evidentiary standards, and other fac-
tors used to apply the limitations de-
described in subclause (I); and

“(III) the application of the limi-
tations described in subclause (I) to 
ensure that such limitations are ap-
plied in parity with respect to both 
medical and surgical benefits and 
mental health and substance use dis-
order benefits.

“(C) NONQUANTITATIVE TREATMENT LIM-
itATIONS.—The guidance issued under this 
paragraph shall include clarifying information 
and illustrative examples of methods, processes, 
strategies, evidentiary standards, and other fac-
tors that group health plans and health insur-
ance issuers offering group or individual health 
insurance coverage may use regarding the de-
velopment and application of nonquantitative treatment limitations to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

“(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

“(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigational;

“(II) limitations with respect to prescription drug formulary design; and

“(III) use of fail-first or step therapy protocols;
“(ii) examples of methods of determining—

“(I) network admission standards (such as credentialing); and

“(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

“(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

“(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

“(v) examples of how specific evidentiary standards may be used to deter-
mine whether treatments are considered experimental or investigative;

“(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

“(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

“(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

“(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for
which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

“(8) COMPLIANCE REQUIREMENTS.—

“(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—Beginning 45 days after the date of enactment of this paragraph, in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as ‘NQTL’) on mental health or substance use disorder benefits, the plan or issuer offering health
insurance coverage shall perform comparative analyses of the design and application of NQTLs in accordance with subparagraph (B), and make available to the applicable State authority (or, as applicable, the Secretary), upon request, the following information:

“(i) The specific plan or coverage terms regarding the NQTL, that applies to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which it applies in each respective benefits classification.

“(ii) The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.

“(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.
“(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to design the NQTL, as written, and the operation processes and strategies as written and in operation that are used to apply the NQTL for mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to design the NQTL, as written, and the operation processes and strategies as written and in operation that are used to apply the NQTL to medical or surgical benefits.

“(v) A disclosure of the specific findings and conclusions reached by the plan or coverage that the results of the analyses described in this subparagraph indicate that the plan or coverage is in compliance with this section.

“(B) SECRETARY REQUEST PROCESS.—

“(i) SUBMISSION UPON REQUEST.—
The Secretary shall request that a group health plan or a health insurance issuer of-
fering group or individual health insurance
coverage submit the comparative analyses
described in subparagraph (A) for plans
that involve potential violations of this sec-
tion or complaints regarding noncompli-
ance with this section that concern NQTLs
and any other instances in which the Sec-
etary determines appropriate. The Sec-
etary shall request not fewer than 20 such
analyses per year.

“(ii) ADDITIONAL INFORMATION.—In
instances in which the Secretary has con-
cluded that the plan or coverage has not
submitted sufficient information for the
Secretary to review the comparative anal-
yses described in subparagraph (A), as re-
quested under clause (i), the Secretary
shall specify to the plan or coverage the in-
formation the plan or coverage must sub-
mit to be responsive to the request under
clause (i) for the Secretary to review the
comparative analyses described in subpara-
graph (A) for compliance with this section.
Nothing in this paragraph shall require the
Secretary to conclude that a plan is in
compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

“(iii) REQUIRED ACTION.—

“(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the plan or coverage is not in compliance with this section, the plan or coverage—

“(aa) shall specify to the Secretary the actions the plan or coverage will take to be in compliance with this section and provide to the Secretary comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or coverage is not in compliance; and
“(bb) following the 45-day corrective action period under item (aa), if the Secretary determines that the plan or coverage still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or coverage that the plan or coverage has been determined to be not in compliance with this section.

“(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary’s recommendations to the plan or coverage shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

“(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—
“(I) a summary of the comparative analyses requested under clause (i), including the identity of each plan or coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

“(II) the Secretary’s conclusions as to whether each plan or coverage submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

“(III) for each plan or coverage that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary’s conclusions as to whether and why the plan or coverage is in compliance with the requirements under this section;

“(IV) the Secretary’s specifications described in clause (ii) for each plan or coverage that the Secretary determined did not submit sufficient
information for the Secretary to re-
view the comparative analyses re-
quested under clause (i) for compli-
ance with this section; and

“(V) the Secretary’s specifica-
tions described in clause (iii) of the
actions each plan or coverage that the
Secretary determined is not in compli-
ance with this section must take to be
in compliance with this section, in-
cluding the reason why the Secretary
determined the plan or coverage is not
in compliance.

“(C) COMPLIANCE PROGRAM GUIDANCE
DOCUMENT UPDATE PROCESS.—

“(i) IN GENERAL.—The Secretary
shall include instances of noncompliance
that the Secretary discovers upon review-
ing the comparative analyses requested
under subparagraph (B)(i) in the compli-
ance program guidance document de-
scribed in paragraph (6), as it is updated
every 2 years, except that such instances
shall not disclose any protected health in-
formation or individually identifiable infor-

``(ii) GUIDANCE AND REGULATIONS.—
Not later than 18 months after the date of
enactment of this paragraph, the Secretary
shall finalize any draft or interim guidance
and regulations relating to mental health
parity under this section. Such draft guid-
ance shall include guidance to clarify the
process and timeline for current and poten-
tial participants and beneficiaries (and au-
thorized representatives and health care
providers of such participants and bene-
ficiaries) with respect to plans to file com-
plaints of such plans or issuers being in
violation of this section, including guid-
ance, by plan type, on the relevant State,
regional, or national office with which such
complaints should be filed.
``(iii) STATE.—The Secretary shall
share information on findings of compli-
ance and noncompliance discovered upon
reviewing the comparative analyses re-
quested under subparagraph (B)(i) with
the State where the group health plan is
located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).

“(b) CONSTRUCTION.—Nothing in this section shall be construed—

“(1) as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits; or

“(2) in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

“(c) EXEMPTIONS.—

“(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer (as defined in section 2791(e)(4), except that for purposes of this paragraph such term
shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

“(2) COST EXEMPTION.—

“(A) IN GENERAL.—With respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.
“(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be—

“(i) 2 percent in the case of the first plan year in which this section is applied; and

“(ii) 1 percent in the case of each subsequent plan year.

“(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

“(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group
health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

“(E) Notification.—

“(i) In general.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

“(ii) Requirement.—A notification to the Secretary under clause (i) shall include—

“(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-
exemption under this paragraph by such plan (or coverage);

“(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

“(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

“(iii) CONFIDENTIALITY.—A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

“(I) a breakdown of States by the size and type of employers submitting such notification; and
“(II) a summary of the data received under clause (ii).

“(F) Audits by appropriate agencies.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

“(d) Separate application to each option offered.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

“(e) Definitions.—For purposes of this section—

“(1) Aggregate lifetime limit.—The term ‘aggregate lifetime limit’ means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount
that may be paid with respect to such benefits under
the plan or health insurance coverage with respect to
an individual or other coverage unit.

“(2) ANNUAL LIMIT.—The term ‘annual limit’
means, with respect to benefits under a group health
plan or health insurance coverage, a dollar limitation
on the total amount of benefits that may be paid
with respect to such benefits in a 12-month period
under the plan or health insurance coverage with re-
spect to an individual or other coverage unit.

“(3) MEDICAL OR SURGICAL BENEFITS.—The
term ‘medical or surgical benefits’ means benefits
with respect to medical or surgical services, as de-
defined under the terms of the plan or coverage (as the
case may be), but does not include mental health or
substance use disorder benefits.

“(4) MENTAL HEALTH BENEFITS.—The term
‘mental health benefits’ means benefits with respect
to services for mental health conditions, as defined
under the terms of the plan and in accordance with
applicable Federal and State law.

“(5) SUBSTANCE USE DISORDER BENEFITS.—
The term ‘substance use disorder benefits’ means
benefits with respect to services for substance use
disorders, as defined under the terms of the plan
and in accordance with applicable Federal and State
law.”.

(2) SUNSET.—Section 2726 of the Public
Health Service Act (42 U.S.C. 300gg–26) is amend-
ed by adding at the end the following new subsection
“(f) SUNSET.—The provisions of this section shall
have no force or effect after the date of the enactment
of the Strengthening Behavioral Health Parity Act.”.

(b) ERISA.—Section 712(a) of the Employee Retire-
ment Income Security Act of 1974 (1185a(a)) is amended
by adding at the end the following new paragraphs:

“(6) COMPLIANCE PROGRAM GUIDANCE DOCU-
MENT.—

“(A) IN GENERAL.—Not later than 12
months after the date of enactment of the
Helping Families in Mental Health Crisis Re-
form Act of 2016, the Secretary, the Secretary
of Health and Human Services, and the Sec-
retary of the Treasury, in consultation with the
Inspector General of the Department of Health
and Human Services, the Inspector General of
the Department of Labor, and the Inspector
General of the Department of the Treasury,
shall issue a compliance program guidance doc-
ument to help improve compliance with this sec-
tion, section 2799A–1 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled ‘Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance’.

“(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

“(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and non-compliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, based on in-
vestigations of violations of such sections, including—

“(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

“(II) descriptions of the violations uncovered during the course of such investigations.

“(ii) NONQUANTITATIVE TREATMENT LIMITATIONS.—To the extent that any example described in clause (i) involves a finding of compliance or noncompliance with regard to any requirement for nonquantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and the criteria involved for approving mental health and substance use disorder benefits.

“(iii) ACCESS TO ADDITIONAL INFORMATION REGARDING COMPLIANCE.—In developing and issuing the compliance program guidance document required under
this paragraph, the Secretaries specified in subparagraph (A)—

“(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable; and

“(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with
this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of nonquantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

“(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to in-
clude illustrative, de-identified examples (that
do not disclose any protected health information
or individually identifiable information) of pre-
vious findings of compliance and nonecompliance
with this section, section 2799A–1 of the Public
Health Service Act, or section 9812 of the In-
ternal Revenue Code of 1986, as applicable.

“(7) ADDITIONAL GUIDANCE.—

“(A) IN GENERAL.—Not later than 12
months after the date of enactment of the
Helping Families in Mental Health Crisis Re-
form Act of 2016, the Secretary, the Secretary
of Health and Human Services, and the Sec-
retary of the Treasury shall issue guidance to
group health plans and health insurance issuers
offering group or individual health insurance
coverage to assist such plans and issuers in sat-
isfying the requirements of this section, section
2799A–1 of the Public Health Service Act, or
section 9812 of the Internal Revenue Code of
1986, as applicable.

“(B) DISCLOSURE.—

“(i) GUIDANCE FOR PLANS AND
ISSUERS.—The guidance issued under this
paragraph shall include clarifying informa-
tion and illustrative examples of methods
that group health plans and health insur-
ance issuers offering group or individual
health insurance coverage may use for dis-
closing information to ensure compliance
with the requirements under this section,
section 2799A–1 of the Public Health
Service Act, or section 9812 of the Inter-
nal Revenue Code of 1986, as applicable,
(and any regulations promulgated pursuant
to such sections, as applicable).

“(ii) DOCUMENTS FOR PARTICIPANTS,
BENEFICIARIES, CONTRACTING PROVIDERS,
OR AUTHORIZED REPRESENTATIVES.—The
guidance issued under this paragraph shall
include clarifying information and illus-
trative examples of methods that group
health plans and health insurance issuers
offering group or individual health insur-
ance coverage may use to provide any par-
ticipant, beneficiary, contracting provider,
or authorized representative, as applicable,
with documents containing information
that the health plans or issuers are re-
quired to disclose to participants, bene-
ficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—

“(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;

“(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

“(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and
mental health and substance use disorder benefits.

“(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such respective section), including—

“(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—
“(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

“(II) limitations with respect to prescription drug formulary design; and

“(III) use of fail-first or step therapy protocols;

“(ii) examples of methods of determining—

“(I) network admission standards (such as credentialing); and

“(II) factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

“(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and
application of nonquantitative treatment limitations;

“(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

“(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

“(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

“(vii) examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness and types of medical management techniques;

“(viii) examples of methods of reaching appropriate coverage determinations for which there is an indirect relationship
between the covered mental health or substance use disorder benefit and a traditional covered medical and surgical benefit, such as residential treatment or hospitalizations involving voluntary or involuntary commitment; and

“(ix) additional illustrative examples of methods, processes, strategies, evidentiary standards, and other factors for which the Secretary determines that additional guidance is necessary to improve compliance with this section, section 2799A–1 of the Public Health Service Act, or section 9812 of the Internal Revenue Code of 1986, as applicable.

“(D) PUBLIC COMMENT.—Prior to issuing any final guidance under this paragraph, the Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

“(8) COMPLIANCE REQUIREMENTS.—

“(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—Beginning 45 days after the date of enactment of this
paragraph, in the case of a group health plan or a health insurance issuer offering group health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as ‘NQTL’) on mental health or substance use disorder benefits, the plan or issuer offering health insurance coverage shall perform comparative analyses of the design and application of NQTLs in accordance with subparagraph (B), and make available to the applicable State authority (or, as applicable, the Secretary), upon request, the following information:

“(i) The specific plan or coverage terms regarding the NQTL, that applies to such plan or coverage, and a description of all mental health or substance use disorder and medical or surgical benefits to which it applies in each respective benefits classification.

“(ii) The factors used to determine that the NQTL will apply to mental health
or substance use disorder benefits and medical or surgical benefits.

“(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

“(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to design the NQTL, as written, and the operation processes and strategies as written and in operation that are used to apply the NQTL for mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to design the NQTL, as written, and the operation processes and strategies as written and in operation that are used to apply the NQTL to medical or surgical benefits.
“(v) A disclosure of the specific findings and conclusions reached by the plan or coverage that the results of the analyses described in this subparagraph indicate that the plan or coverage is in compliance with this section.

“(B) SECRETARY REQUEST PROCESS.—

“(i) SUBMISSION UPON REQUEST.—

The Secretary shall request that a group health plan or a health insurance issuer offering group health insurance coverage submit the comparative analyses described in subparagraph (A) for plans that involve potential violations of this section or complaints regarding noncompliance with this section that concern NQTLs and any other instances in which the Secretary determines appropriate. The Secretary shall request not fewer than 20 such analyses per year.

“(ii) ADDITIONAL INFORMATION.—In instances in which the Secretary has concluded that the plan or coverage has not submitted sufficient information for the Secretary to review the comparative anal-
yses described in subparagraph (A), as re-
quested under clause (i), the Secretary
shall specify to the plan or coverage the in-
formation the plan or coverage must sub-
mit to be responsive to the request under
clause (i) for the Secretary to review the
comparative analyses described in subpara-
graph (A) for compliance with this section.

Nothing in this paragraph shall require the
Secretary to conclude that a plan is in
compliance with this section solely based
upon the inspection of the comparative
analyses described in subparagraph (A), as
requested under clause (i).

“(iii) REQUIRED ACTION.—

“(I) IN GENERAL.—In instances
in which the Secretary has reviewed
the comparative analyses described in
subparagraph (A), as requested under
clause (i), and determined that the
plan or coverage is not in compliance
with this section, the plan or cov-

erage—

“(aa) shall specify to the
Secretary the actions the plan or
coverage will take to be in compliance with this section and provide to the Secretary comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan or coverage is not in compliance; and

“(bb) following the 45-day corrective action period under item (aa), if the Secretary determines that the plan or coverage still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or coverage that the plan or coverage has been determined to be not in compliance with this section.

“(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the
Secretary’s recommendations to the plan or coverage shall not be subject to disclosure pursuant to section 552 of title 5, United States Code.

“(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

“(I) a summary of the comparative analyses requested under clause (i), including the identity of each plan or coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

“(II) the Secretary’s conclusions as to whether each plan or coverage submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

“(III) for each plan or coverage that did submit sufficient information
for the Secretary to review the comparative analyses requested under clause (i), the Secretary’s conclusions as to whether and why the plan or coverage is in compliance with the requirements under this section;

“(IV) the Secretary’s specifications described in clause (ii) for each plan or coverage that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

“(V) the Secretary’s specifications described in clause (iii) of the actions each plan or coverage that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or coverage is not in compliance.

“(C) COMPLIANCE PROGRAM GUIDANCE DOCUMENT UPDATE PROCESS.—
“(i) IN GENERAL.—The Secretary shall include instances of noncompliance that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

“(ii) GUIDANCE AND REGULATIONS.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include 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 plans to file complaints of such plans or issuers being in violation of this section, including guid-
ance, by plan type, on the relevant State, regional, or national office with which such complaints should be filed.

“(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).”.

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

“(6) COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—

“(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of Health and Human Services, in consultation with the In-
specter General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 2799A–1 of the Public Health Service Act, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled ‘Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance’.

“(B) EXAMPLES ILLUSTRATING COMPLIANCE AND NONCOMPLIANCE.—

“(i) IN GENERAL.—The compliance program guidance document required under this paragraph shall provide illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of
previous findings of compliance and non-compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable, based on investigations of violations of such sections, including—

“(I) examples illustrating requirements for information disclosures and nonquantitative treatment limitations; and

“(II) descriptions of the violations uncovered during the course of such investigations.

“(ii) **NONQUANTITATIVE TREATMENT LIMITATIONS.**—To the extent that any example described in clause (i) involves a finding of compliance or none compliance with regard to any requirement for non-quantitative treatment limitations, the example shall provide sufficient detail to fully explain such finding, including a full description of the criteria involved for approving medical and surgical benefits and
the criteria involved for approving mental health and substance use disorder benefits.

“(iii) Access to additional information regarding compliance.—In developing and issuing the compliance program guidance document required under this paragraph, the Secretaries specified in subparagraph (A)—

“(I) shall enter into interagency agreements with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury to share findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable; and

“(II) shall seek to enter into an agreement with a State to share information on findings of compliance and noncompliance with this section, sec-
tion 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable.

“(C) RECOMMENDATIONS.—The compliance program guidance document shall include recommendations to advance compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable, and encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements. Such internal controls may include illustrative examples of non-quantitative treatment limitations on mental health and substance use disorder benefits, which may fail to comply with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable, in relation to nonquantitative treatment limitations on medical and surgical benefits.

“(D) UPDATING THE COMPLIANCE PROGRAM GUIDANCE DOCUMENT.—The Secretary,
the Secretary of Labor, and the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall update the compliance program guidance document every 2 years to include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable information) of previous findings of compliance and noncompliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable.

“(7) ADDITIONAL GUIDANCE.—

“(A) IN GENERAL.—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of Health and Human Services shall issue guidance to group health plans and health insurance issuers offering group or individual health insurance cov-
verage to assist such plans and issuers in satisfying the requirements of this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable.

“(B) Disclosure.—

"(i) Guidance for plans and issuers.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, (and any regulations promulgated pursuant to such sections, as applicable).

"(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives.—The guidance issued under this paragraph shall include clarifying information and illus-
trative examples of methods that group
health plans and health insurance issuers
offering group or individual health insur-
ance coverage may use to provide any par-
ticipant, beneficiary, contracting provider,
or authorized representative, as applicable,
with documents containing information
that the health plans or issuers are re-
quired to disclose to participants, bene-
ficiaries, contracting providers, or author-
ized representatives to ensure compliance
with this section, section 712 of the Em-
ployee Retirement Income Security Act of
1974, or section 2799A–1 of the Public
Health Service Act, as applicable, compli-
ance with any regulation issued pursuant
to such respective section, or compliance
with any other applicable law or regula-
tion. Such guidance shall include informa-
tion that is comparative in nature with re-
spect to—

“(I) nonquantitative treatment
limitations for both medical and sur-
gical benefits and mental health and
substance use disorder benefits;
“(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and

“(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.

“(C) NONQUANTITATIVE TREATMENT LIMITATIONS.—The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that group health plans and health insurance issuers offering group or individual health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 2799A–1 of the Public Health Service Act, as applicable, (and any regulations promulgated
pursuant to such respective section), including—

“(i) examples of methods of determining appropriate types of nonquantitative treatment limitations with respect to both medical and surgical benefits and mental health and substance use disorder benefits, including nonquantitative treatment limitations pertaining to—

“(I) medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;

“(II) limitations with respect to prescription drug formulary design;

and

“(III) use of fail-first or step therapy protocols;

“(ii) examples of methods of determining—

“(I) network admission standards (such as credentialing); and

“(II) factors used in provider reimbursement methodologies (such as service type, geographic market, de-
mand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy;

“(iii) examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of nonquantitative treatment limitations;

“(iv) examples of specific factors, and the evidentiary standards used to evaluate such factors, used by such plans or issuers in performing a nonquantitative treatment limitation analysis;

“(v) examples of how specific evidentiary standards may be used to determine whether treatments are considered experimental or investigative;

“(vi) examples of how specific evidentiary standards may be applied to each service category or classification of benefits;

“(vii) examples of methods of reaching appropriate coverage determinations
for new mental health or substance use
disorder treatments, such as evidence-
based early intervention programs for indi-
viduals with a serious mental illness and
types of medical management techniques;
“(viii) examples of methods of reaching
appropriate coverage determinations
for which there is an indirect relationship
between the covered mental health or sub-
stance use disorder benefit and a tradi-
tional covered medical and surgical benefit,
such as residential treatment or hos-
pitalizations involving voluntary or involun-
tary commitment; and
“(ix) additional illustrative examples
of methods, processes, strategies, evi-
dentiary standards, and other factors for
which the Secretary determines that addi-
tional guidance is necessary to improve
compliance with this section, section 712 of
the Employee Retirement Income Security
Act of 1974, or section 2799A–1 of the
Public Health Service Act, as applicable.
“(D) PUBLIC COMMENT.—Prior to issuing
any final guidance under this paragraph, the
Secretary shall provide a public comment period of not less than 60 days during which any member of the public may provide comments on a draft of the guidance.

“(8) COMPLIANCE REQUIREMENTS.—

“(A) NONQUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS.—Beginning 45 days after the date of enactment of this paragraph, in the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as ‘NQTL’) on mental health or substance use disorder benefits, the plan shall perform comparative analyses of the design and application of NQTLs in accordance with subparagraph (B), and make available to the applicable State authority (or, as applicable, the Secretary), upon request, the following information:

“(i) The specific plan terms regarding the NQTL, that applies to such plan or coverage, and a description of all mental health or substance use disorder and med-
ical or surgical benefits to which it applies in each respective benefits classification.

“(ii) The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.

“(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

“(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to design the NQTL, as written, and the operation processes and strategies as written and in operation that are used to apply the NQTL for mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used
to design the NQTL, as written, and the
operation processes and strategies as writ-
ten and in operation that are used to apply
the NQTL to medical or surgical benefits.

“(v) A disclosure of the specific find-
ings and conclusions reached by the plan
that the results of the analyses described
in this subparagraph indicate that the plan
is in compliance with this section.

“(B) SECRETARY REQUEST PROCESS.—

“(i) SUBMISSION UPON REQUEST.—
The Secretary shall request that a group
health plan submit the comparative anal-
yses described in subparagraph (A) for
plans that involve potential violations of
this section or complaints regarding non-
compliance with this section that concern
NQTLs and any other instances in which
the Secretary determines appropriate. The
Secretary shall request not fewer than 20
such analyses per year.

“(ii) ADDITIONAL INFORMATION.—In
instances in which the Secretary has con-
cluded that the plan has not submitted suf-
ficient information for the Secretary to re-
view the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan the information the plan or coverage must submit to be responsive to the request under clause (i) for the Secretary to review the comparative analyses described in subparagraph (A) for compliance with this section. Nothing in this paragraph shall require the Secretary to conclude that a plan is in compliance with this section solely based upon the inspection of the comparative analyses described in subparagraph (A), as requested under clause (i).

“(iii) REQUIRED ACTION.—

“(I) IN GENERAL.—In instances in which the Secretary has reviewed the comparative analyses described in subparagraph (A), as requested under clause (i), and determined that the plan is not in compliance with this section, the plan—

“(aa) shall specify to the Secretary the actions the plan will take to be in compliance with
this section and provide to the Secretary comparative analyses described in subparagraph (A) that demonstrate compliance with this section not later than 45 days after the initial determination by the Secretary that the plan is not in compliance; and

“(bb) following the 45-day corrective action period under item (aa), if the Secretary determines that the plan still is not in compliance with this section, not later than 7 days after such determination, shall notify all individuals enrolled in the plan or coverage that the plan has been determined to be not in compliance with this section.

“(II) EXEMPTION FROM DISCLOSURE.—Documents or communications produced in connection with the Secretary’s recommendations to the plan or coverage shall not be subject
to disclosure pursuant to section 552 of title 5, United States Code.

“(iv) REPORT.—Not later than 1 year after the date of enactment of this paragraph, and not later than October 1 of each year thereafter, the Secretary shall submit to Congress, and make publicly available, a report that contains—

“(I) a summary of the comparative analyses requested under clause (i), including the identity of each plan that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb);

“(II) the Secretary’s conclusions as to whether each plan submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

“(III) for each plan that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the
Secretary’s conclusions as to whether and why the plan or coverage is in compliance with the requirements under this section;

“(IV) the Secretary’s specifications described in clause (ii) for each plan that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section; and

“(V) the Secretary’s specifications described in clause (iii) of the actions each plan that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or coverage is not in compliance.

“(C) Compliance program guidance document update process.—

“(i) In general.—The Secretary shall include instances of nonecompliance
that the Secretary discovers upon reviewing the comparative analyses requested under subparagraph (B)(i) in the compliance program guidance document described in paragraph (6), as it is updated every 2 years, except that such instances shall not disclose any protected health information or individually identifiable information.

“(ii) GUIDANCE AND REGULATIONS.—

Not later than 18 months after the date of enactment of this paragraph, the Secretary shall finalize any draft or interim guidance and regulations relating to mental health parity under this section. Such draft guidance shall include 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 plans to file complaints of such plans or issuers being in violation of this section, including guidance, by plan type, on the relevant State,
regional, or national office with which such complaints should be filed.

“(iii) STATE.—The Secretary shall share information on findings of compliance and noncompliance discovered upon reviewing the comparative analyses requested under subparagraph (B)(i) with the State where the group health plan is located or the State where the health insurance issuer is licensed to do business for coverage offered by a health insurance issuer in the group market, in accordance with paragraph (6)(B)(iii)(II).”.

(d) IMPLEMENTATION.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may implement the paragraph (8) of section 2799A–1(a) of the Public Health Service Act, added by subsection (a), the paragraph (8) of section 712(a) of the Employee Retirement Income Security Act of 1974, as added by subsection (b), and the paragraph (8) of section 9812(a) of the Internal Revenue Code of 1986, as added by subsection (c), by program instruction, guidance, or otherwise.