in connection with a group health plan, may not—

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) Rules of construction

(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

(A) to give birth in a hospital; or

(B) to stay in the hospital for a fixed period of time following the birth of her child.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) Notice under group health plan

The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 1022(a)(1)[1] of this title, for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 1024(b)(1) of this title with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

(e) Level and type of reimbursements

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) Preemption; exception for health insurance coverage in certain States

(1) In general

The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 1191(d)(1) of this title) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

(2) Construction

Section 1191(a)(1) of this title shall not be construed as superseding a State law described in paragraph (1).

(Pub. L. 93–406, title I, § 711, as added Pub. L. 104–204, title VI, § 603(a)(5), Sept. 26, 1996, 110 Stat. 2935.)

Editorial Notes

REFERENCES IN TEXT

Section 1022(a)(1) of this title, referred to in subsec. (d), was redesignated section 1022(a) of this title by Pub. L. 105–34, title XV, § 1503(b)(1)(B), Aug. 5, 1997, 111 Stat. 1061.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE

Section applicable with respect to group health plans for plan years beginning on and after Jan. 1, 1998, see section 603(c) of Pub. L. 104–204, set out as an Effective Date of 1996 Amendment note under section 1003 of this title.

§ 1185a. 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 health insurance coverage offered in connection with such a plan) 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

[1] See References in Text note below.

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 either—

(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 application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

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

(C) Rule in case of different limits

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 computed 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 health insurance coverage offered in connection with such a plan) 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 annual limit.

(C) Rule in case of different limits

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 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 annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations

(A) In general

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) 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:

(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),[1]

(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

[1] So in original. The comma probably should be a period.

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

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 issue a compliance program guidance document to help improve compliance with this section, section 300gg–26 of title 42, and section 9812 of title 26, 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 noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, 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 300gg–26 of title 42, or section 9812 of title 26, 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 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(C) Recommendations

The compliance program guidance document shall include recommendations to advance compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, 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 300gg–26 of title 42, or section 9812 of title 26, 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 include illustrative, de-identified examples (that do not disclose any protected health information or individually identifiable informa-

tion) of previous findings of compliance and noncompliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, as applicable.

(7) Additional guidance

(A) In general

The Secretary, the Secretary of Health and Human Services, and the Secretary of the Treasury shall issue guidance to group health plans and health insurance issuers offering group health insurance coverage to assist such plans and issuers in satisfying the requirements of this section, section 300gg–26 of title 42, or section 9812 of title 26, 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 300gg–26 of title 42, or section 9812 of title 26, 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 illustrative examples of methods that group health plans and health insurance issuers offering group health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, 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 health insurance coverage may use regarding the development and application of nonquantitative treatment limitations to ensure compliance with this section, section 300gg–26 of title 42, or section 9812 of title 26, 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 300gg–26 of title 42, or section 9812 of title 26, 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

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 ''NQTLs'') on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the Secretary, upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs, 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 each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs 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 NQTLs 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 apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not 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 group health plan or health insurance issuer with respect to group health insurance coverage has not submitted sufficient information for the Secretary to review the comparative analyses described in subparagraph (A), as requested under clause (i), the Secretary shall specify to the plan or issuer the information the plan or issuer 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 group health plan or health insurance issuer 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 group health plan or health insurance issuer is not in compliance with this section, the plan or issuer—

(aa) shall specify to the Secretary the actions the plan or issuer will take to be in compliance with this section and provide to the Secretary additional 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 issuer is not in compliance; and

(bb) following the 45-day corrective action period under item (aa), if the Secretary makes a final determination that the plan or issuer 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 applicable health insurance coverage offered by the issuer that the plan or issuer, with respect to such 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 a group health plan or health insurance issuer shall not be subject to disclosure pursuant to section 552 of title 5.

(iv) Report

Not later than 1 year after December 27, 2020, 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 group health plan or health insurance issuer, with respect to certain health insurance 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 group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section;

(III) for each group health plan or health insurance issuer 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 issuer is in compliance with the disclosure requirements under this section;

(IV) the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer 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 group health plan or health insurance issuer 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 issuer 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 December 27, 2020, 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) shall be shared 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 health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) 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

(A) In general

This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

(B) Small employer

For purposes of subparagraph (A), the term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

(C) Application of certain rules in determination of employer size

For purposes of this paragraph—

(i) Application of aggregation rule for employers

Rules similar to the rules under subsections (b), (c), (m), and (*o*) of section 414

of title 26 shall apply for purposes of treating persons as a single employer.

(ii) Employers not in existence in preceding year

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Predecessors

Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(2) Cost exemption

(A) In general

With respect to a group health plan (or health insurance coverage offered in connection with such a plan), 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 respect 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 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.

(f) Secretary report

The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

(g) Notice and assistance

The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.

(Pub. L. 93–406, title I, § 712, as added Pub. L. 104–204, title VII, § 702(a), Sept. 26, 1996, 110 Stat. 2944; amended Pub. L. 107–116, title VII, § 701(a), Jan. 10, 2002, 115 Stat. 2228; Pub. L. 107–313, § 2(a), Dec. 2, 2002, 116 Stat. 2457; Pub. L. 108–197, § 2(a), Dec. 19, 2003, 117 Stat. 2898; Pub. L. 108–311, title III, § 302(b), Oct. 4, 2004, 118 Stat. 1178; Pub. L. 109–151, § 1(a), Dec. 30, 2005, 119 Stat. 2886; Pub. L. 109–432, div. A, title I, § 115(b), Dec. 20, 2006, 120 Stat. 2941; Pub. L. 110–245, title IV, § 401(b), June 17, 2008, 122 Stat. 1649; Pub. L. 110–343, div. C, title V, § 512(a), (g)(1)(A), Oct. 3, 2008, 122 Stat. 3881, 3892; Pub. L. 116–260, div. BB, title II, § 203(a)(2), Dec. 27, 2020, 134 Stat. 2903.)

Editorial Notes

AMENDMENTS

2020—Subsec. (a)(6) to (8). Pub. L. 116–260 added pars. (6) to (8).

2008—Pub. L. 110–343, § 512(g)(1)(A), amended section catchline generally. Prior to amendment, catchline read as follows: ''Parity in application of certain limits to mental health benefits''.

Subsec. (a)(1), (2). Pub. L. 110–343, § 512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(introductory provisions), (A), and (B)(ii) and (2)(introductory provisions), (A), and (B)(ii).

Pub. L. 110–343, § 512(a)(7), substituted ''mental health and substance use disorder benefits'' for ''mental health benefits'' wherever appearing in pars. (1)(B)(i) and (C) and (2)(B)(i) and (C).

Subsec. (a)(3) to (5). Pub. L. 110–343, § 512(a)(1), added pars. (3) to (5).

Subsec. (b)(1). Pub. L. 110–343, § 512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (b)(2). Pub. L. 110–343, § 512(a)(2), amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).''

Subsec. (c)(1)(B). Pub. L. 110–343, § 512(a)(3)(A), inserted ''(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)'' after ''of at least 2'' and struck out ''and who employs at least 2 employees on the first day of the plan year'' after ''preceding calendar year''.

Subsec. (c)(2). Pub. L. 110–343, § 512(a)(3)(B), added par. (2) and struck out former par. (2). Prior to amendment, text read as follows: ''This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.''

Subsec. (e)(3). Pub. L. 110–343, § 512(a)(8), substituted ''mental health or substance use disorder benefits'' for ''mental health benefits''.

Subsec. (e)(4). Pub. L. 110–343, § 512(a)(8), which directed amendment of this section by substituting ''mental health or substance use disorder benefits'' for

''mental health benefits'' wherever appearing (except in provisions amended by Pub. L. 110–343, § 512(a)(7)), was not executed to par. (4) as added by Pub. L. 110–343, § 512(a)(4), to reflect the probable intent of Congress. See below.

Pub. L. 110–343, § 512(a)(4), added par. (4) and struck out former par. (4). Text read as follows: ''The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.''

Subsec. (e)(5). Pub. L. 110–343, § 512(a)(4), added par. (5).

Subsec. (f). Pub. L. 110–343, § 512(a)(6), added subsec. (f).

Pub. L. 110–343, § 512(a)(5), struck out subsec. (f). Text read as follows: ''This section shall not apply to benefits for services furnished—

''(1) on or after January 1, 2008, and before June 17, 2008, and

''(2) after December 31, 2008..''

Pub. L. 110–245 substituted ''services furnished—'' for ''services furnished after December 31, 2007'' and added pars. (1) and (2).

Subsec. (g). Pub. L. 110–343, § 512(a)(6), added subsec. (g).

2006—Subsec. (f). Pub. L. 109–432 substituted ''2007'' for ''2006''.

2005—Subsec. (f). Pub. L. 109–151 substituted ''December 31, 2006'' for ''December 31, 2005''.

2004—Subsec. (f). Pub. L. 108–311 substituted ''after December 31, 2005'' for ''on or after December 31, 2004''.

2003—Subsec. (f). Pub. L. 108–197 substituted ''December 31, 2004'' for ''December 31, 2003''.

2002—Subsec. (f). Pub. L. 107–313 substituted ''December 31, 2003'' for ''December 31, 2002''.

Pub. L. 107–116 substituted ''December 31, 2002'' for ''September 30, 2001''.

Statutory Notes and Related Subsidiaries

EFFECTIVE DATE OF 2008 AMENDMENT

Amendment by Pub. L. 110–343 applicable with respect to group health plans for plan years beginning after the date that is 1 year after Oct. 3, 2008, except that amendment by section 512(a)(5) of Pub. L. 110–343 effective Jan. 1, 2009, with special rule for collective bargaining agreements, see section 512(e) of Pub. L. 110–343, set out as a note under section 300gg–26 of Title 42, The Public Health and Welfare.

EFFECTIVE DATE

Pub. L. 104–204, title VII, § 702(c), Sept. 26, 1996, 110 Stat. 2946, provided that: ''The amendments made by this section [enacting this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.''

§ 1185b. Required coverage for reconstructive surgery following mastectomies

(a) In general

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) Notice

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

(2) as part of any yearly informational packet sent to the participant or beneficiary; or

(3) not later than January 1, 1999;

whichever is earlier.

(c) Prohibitions

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Rule of construction

Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) Preemption, relation to State laws

(1) In general

Nothing in this section shall be construed to preempt any State law in effect on October 21, 1998, with respect to health insurance coverage that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) ERISA

Nothing in this section shall be construed to affect or modify the provisions of section 1144 of this title with respect to group health plans.