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Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS

WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

RECEIVED

SEP 21 2007

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September 21, 2007

The Honorable Charles B. Rangel
Chairman
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

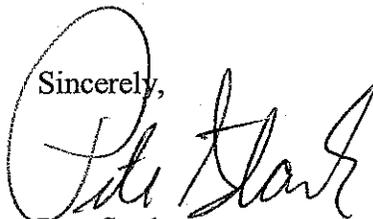
Dear Mr. Chairman:

On September 19, 2007 the Subcommittee on Health ordered favorably reported to the Full Committee, H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007," as amended, by a roll call vote of 10 yeas to 3 nays.

The Subcommittee proposal would provide parity for all mental health and substance abuse-related disorder benefits under group health plans.

Transmitted herein, in accordance with Committee Rule 11, is a report containing a comparison with present law, a section-by-section analysis of the proposed changes, a section-by-section justification, a committee estimate of the budgetary effects of the bill. While not required by Committee Rule 11, also included are the votes of the Subcommittee.

Sincerely,



Pete Stark
Chairman

**Committee on Ways and Means
Subcommittee on Health
Subcommittee Report on HR 1424
The “Paul Wellstone Mental Health and Addiction Equity Act of 2007”**

A. PURPOSE AND SUMMARY

Purpose

Millions of Americans suffer from mental illness; however, obstacles within our health care system prevent many from getting the care they desperately need. The *Paul Wellstone Mental Health and Addiction Equity Act* (H.R. 1424) will expand the *Mental Health Parity Act of 1996*¹ to ensure that mental illnesses are covered under similar terms as physical illnesses for the millions of Americans who currently receive health care through their employers.

Summary

Section 1 is the Short Title and Table of Contents. Sections 2 and 3 amend the Employee Retirement Income Security Act of 1974 and the Public Health Service Act provisions relating to the group market, respectively. Section 4 amends the Internal Revenue Code. Section 5 directs the Government Accountability Office to conduct studies and report findings. This report is limited to proposed statutory changes within the Committee’s jurisdiction, and so only covers Section 4.

B. DESCRIPTION OF PRESENT LAW

The Code, the Employee Retirement Income Security Act of 1974 (“ERISA”) and the Public Health Service Act (“PHSA”) contain provisions under which group health plans that provide both medical and surgical benefits and mental health benefits cannot impose aggregate lifetime or annual dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits (“mental health parity requirements”). In the case of a group health plan which provides benefits for mental health, the mental health parity requirements do not affect 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, except as specifically provided in regard to parity in the imposition of aggregate lifetime limits and annual limits.

The Code imposes an excise tax on group health plans which fail to meet the mental health parity requirements. The excise tax is equal to \$100 per day during the period of noncompliance and is generally imposed on the employer sponsoring the plan if the plan fails to meet the requirements. In the case of violations which are not corrected before the date a notice of examination is sent to the employer and which occurred or continued during the period under examination, the excise tax cannot be less than the lesser of \$2,500 or the amount of tax imposed under the general rule.

¹ P.L. 104-204

In the case that violations are more than de minimis, the tax cannot be less than the lesser of \$15,000 or the amount imposed under the general rule. The maximum tax that can be imposed during a taxable year cannot exceed the lesser of 10 percent of the employer's group health plan expenses for the prior year or \$500,000. No tax is imposed if the Secretary determines that the employer did not know, and in exercising reasonable diligence would not have known, that the failure existed.

The mental health parity requirements do not apply to group health plans of small employers. A small employer generally includes an employer who employs at least two, but no more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.² The mental health parity requirements also do not apply if their application results in an increase in the cost under a group health plan of at least one percent. Further, the mental health parity requirements do not require group health plans to provide mental health benefits.

The Code, ERISA and PHSa mental health parity requirements are scheduled to expire with respect to benefits for services furnished after December 31, 2007.

C. SECTION 4. EXPLANATION OF PROPOSAL

In General

Section 4 of the bill modifies the mental health parity requirements under the Code and also expands the application of such requirements to substance-related disorder benefits.³ This expansion applies to the rules under present law and to the changes under the provision.

The provision also eliminates the sunset under present law and makes the requirements for group health plans relating to mental health and substance-related disorder benefits permanent.

Treatment Limits

Under the provision, in the case of a group health plan that provides both medical and surgical and mental health or substance-related disorder benefits, if the plan does not include a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan may not impose any treatment limit on mental health and substance-related disorder benefits that are classified in the same category of items or services. A treatment limit means, with respect to a plan, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan.

If the plan includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan may not impose such a treatment limit on mental health or

² The group health plan requirements do not apply to any group health plan for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees.

³ The term "substance related disorder benefits" means benefits with respect to services for substance-related disorders, as defined under the terms of the plan.

substance-related disorder benefits for items and services within such category that is more restrictive than the predominant⁴ treatment limit that is applicable to medical and surgical benefits for items and services within such category.

The provision provides five categories of items and services for benefits. All medical and surgical benefits and all mental health and substance related benefits must be classified into one of the five categories. The five categories are as follows:

1. Inpatient, in-network -- Items and services, not described in (5) below, furnished on an inpatient basis and within a network of providers established or recognized under such plan.
2. Inpatient, out-of-network -- Items and services, not described in (5) below, furnished on an inpatient basis and outside any network of providers established or recognized under such plan.
3. Outpatient, in-network -- Items and services, not described in (5) below, furnished on an outpatient basis and within a network of providers established or recognized under such plan.
4. Outpatient, out-of-network -- Items and services, not described in (5) below, furnished on an outpatient basis and outside any network of providers established or recognized under such plan.
5. Emergency care -- Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (including an emergency medical condition relating to mental health or substance-related disorders).

Beneficiary Financial Requirements

The provision provides that in the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if the plan does not include a beneficiary financial requirement on substantially all medical and surgical benefits within a category of items and services (listed above), the plan may not impose such a beneficiary financial requirement on mental health or substance-related disorder benefits for items and services within such category.

A beneficiary financial requirement includes, with respect to a plan, any deductible, coinsurance, co-payment, other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan. A beneficiary financial requirement does not include the application of any aggregate lifetime limit or annual limit.

⁴ A treatment limit with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of limit with respect to such category of items and services.

If a plan includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan must apply such requirement⁵ both to medical and surgical benefits within such category and mental health and substance-related disorder benefits within such category and may not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

If a plan includes a beneficiary financial requirement not described in the preceding paragraph on substantially all medical and surgical benefits within a category of items and services, the plan may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that results in greater out-of-pocket expenses to the participant or beneficiary than the predominate beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category. The provision does not prohibit the plan from waiving the application of any deductible for mental health benefits or substance-related disorder benefits (or both).

The provision deletes the present law rule that the mental health parity requirements should not be construed as affecting the terms and conditions of mental health benefits under a plan.

Availability Of Plan Information Regarding Criteria For Medical Necessity

The provision also provides that the criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contract provider upon request. The reason for any denial under the plan of reimbursement or payment for services with respect to mental health and substance-related disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator to the participant or beneficiary upon request.

Minimum Benefit Requirements

The provision provides rules for the minimum benefits that must be provided in the case of a plan that provides mental health and substance-related disorder benefits. Under the provision, in the case of a group health plan that provides any mental health or substance-related disorder benefits, the plan must include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under the Federal Employees' Health Benefits Program (FEHBP) with the highest average enrollment as of the beginning of the most recent year beginning on or before the beginning of the plan year involved.

In the case of a plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if medical and surgical benefits are provided for substantially

⁵ If there is more than one such requirement for such category of items and services, the rule applies to the predominate requirement for such category. A financial requirement with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of requirement with respect to such category of items and services.

all items and services in a category specified below furnished outside any network of providers established or recognized under such plan, the mental health and substance-related disorder benefits must also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan in accordance with the requirements under the provision. The three categories are as follows:

1. Emergency -- Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (including an emergency condition relating to mental health or substance-related disorders).
2. Inpatient -- Items and services not described in (1) furnished on an inpatient basis.
3. Outpatient -- Items and services not described in (1) furnished on an outpatient basis.

Increased Cost Exception

The provision modifies the increased cost exemption under present law. Under the provision, if the application of the mental health and substance-related disorder parity requirements results in an increase for the plan year involved of the actual total costs of coverage⁶ by an amount that exceeds one percent (two percent in the case of the first plan year to which the provision applies) of the actual total plan costs, such requirements do not apply to the plan during the following plan year. This exception applies to the plan for one plan year. If a plan seeks use of the exemption, the determination whether the exemption applies must be made after the plan has complied with the rules for the first six months of the plan year involved.

Determinations as to increases in actual costs under a plan for purposes of this exemption must be made by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. The determination must be certified by the actuary and made available to the general public.

The provision does not effect the application of State law requirements or exceptions.

Small Employer Exception

The provision also modifies the small employer exemption. Under the provision, a small employer is an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year. Under the provision, a small employer also includes an employer who employed on average at least one employee during such period in the case of an employer residing in a State that permits small groups to include a single individual.

Effective Date

The provision is effective with respect to plan years beginning on or after January 1, 2008. The elimination of the sunset of the present law mental health parity requirements is effective for benefits for services furnished after December 31, 2007.

⁶ Coverage refers to medical and surgical benefits and mental health and substance-related disorder benefits under the plan.

In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment, the provision (other than the elimination of the sunset) does not apply to plan years beginning before the later of (1) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment), or (2) January 1, 2010. Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan

D. SECTION 4. REASON FOR CHANGE

Mental disorders are the leading cause of disability in the U.S. for individuals ages 15-44.⁷ However, private health insurers and employers generally provide less coverage for mental illnesses than for other medical and surgical benefits through the use of plan design features. H.R. 1424 seeks to increase access to mental health treatment by prohibiting group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual lifetime limits) or treatment limitations (including limitations on the number of visits, days of coverage, frequency of treatment, or other similar limits on the scope and duration of treatment) on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits.

Parity in mental health is needed because of the enormous impact that mental illness and substance abuse has on our society. Mental illness and substance abuse result in substantial lost productivity and absenteeism. It has been determined that mental illness and substance abuse cause more days of work loss and work impairment than many other chronic conditions such as diabetes, arthritis, and asthmas. Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing employers approximately \$17 billion each year.⁸

Employers and insurance companies routinely discriminate against mental health coverage when it comes to reimbursing individuals for their mental benefits. Insurers often increase patients' costs for mental health treatment by limiting inpatient days, capping outpatient visits, and requiring higher co-payments than for physical illnesses. It is estimated that over 90 percent of workers with employer-sponsored health insurance are enrolled in plans that impose higher costs in at least one of these ways. Furthermore, 48 percent are enrolled in plans that impose all three limitations.⁹

⁷ The World Health Organization. *The World Health Report 2004: Changing History*; Annex Table 3: Burden of disease in Disability-Adjusted-Life-Years (DALY) by cause, sex, and mortality stratum in WHO regions, estimates for 2002. Geneva (2004).

⁸ Dr. Robin Hertz. "The Impact of Mental Disorders on Work." Pfizer Pharmaceutical Group. (June 2002) available at http://www.pfizer.com/pfizer/download/health/pubs_facts_workimpact.pdf.

⁹ Colleen Barry et al., "Design of Mental Health Benefits: Still Unequal After All These Years," *Health Affairs*, September/October 2003.

HR 1424 includes two important provisions necessary to end discrimination against people with mental illness and addiction. First, recognizing the Diagnostic and Statistical Manual (DSM) as the minimum benefit standard ensures appropriate, scientifically-based coverage of these conditions. The DSM was developed by more than 1,000 national and international health care researchers and clinicians drawn from a wide range of mental and general health fields and is widely acknowledged as the empirical guide for diagnosing mental health disorders. Without this standard, plans could continue the practice of using arbitrary, non-scientific criteria in determining what mental illnesses and addictive disorders they cover.

Mental health and substance abuse conditions are the only disorders that have been systematically and unfairly excluded from equal coverage. Unlike mental health, the usual medical/surgical categorical exclusions made by insurers are for treatments or procedures such as cosmetic surgery, not for a whole class of diagnoses. Because of the historical precedence of exclusion and discrimination, HR 1424 takes necessary steps to clarify and require that such exclusions are no longer acceptable or legal.

Secondly, extending the requirement to out-of-network services is necessary to achieve true parity. If a plan covers out-of-network services for physical health, it should also provide out-of-network services for mental health. Furthermore, restricting access to services provided "in-network" seriously limits treatment options and availability of appropriate providers.

Passage of HR 1424 will end the legal discrimination that people with mental illness and addition have suffered in our society. The Subcommittee urges its swift passage.

E. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 1424, as reported.

The effects of the bill on Federal budget receipts are presented in the revenue table from the Joint Committee on Taxation (see below).

ESTIMATED REVENUE EFFECTS OF THE CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO THE REVENUE PROVISIONS OF H.R. 1424,
 THE "PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007,"
 SCHEDULED FOR MARKUP BY THE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH, ON SEPTEMBER 19, 2007

Fiscal Years 2008 - 2017
 [Millions of Dollars]

Provision	Effective	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
Modification and Permanent Extension of Mental Health Party Requirements Applicable to Group Health Plans; Apply Requirements to Substance-Related Disorder Benefits [1]	generally pybo/a 1/1/08	-30	-190	-270	-290	-320	-350	-380	-400	-430	-460	-1,100	-3,120

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding. Date of enactment is assumed to be October 1, 2007.

Legend for "Effective" column: pybo/a = plan years beginning on or after

[1] Estimate provided by the Congressional Budget Office.

F. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning votes of the Subcommittee on Health of the Committee on Ways and Means in consideration of the bill, H.R. 1424 the "Paul Wellstone Mental Health and Addiction Equity Act of 2007".

The bill, H.R. 1424, as amended, was favorably reported by a roll call vote of 10 yeas to 3 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....	x			Mr. CAMP.....			x
Mr. DOGGET.....	x			Mr. JOHNSON.....			x
Mr. THOMPSON.....	x			Mr. RAMSTAD.....	x		
Mr. EMANUEL.....	x			Mr. ENGLISH	x		
Mr. BECERRA.....	x			Mr. HULSHOF.....			x
Mr. POMEROY.....	x						
Ms. TUBBS JONES...	x						
Mr. KIND.....	x						

VOTES ON AMENDMENTS

An amendment by Mr. Camp to strike subparagraph (B) of section 4(d) so a plan is not required to provide out-of-network mental health benefits if it also provides out-of-network medical and surgical benefits was defeated by a roll call vote of 4 yeas to 8 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....		x		Mr. CAMP.....	x		
Mr. DOGGET.....		x		Mr. JOHNSON.....	x		
Mr. THOMPSON.....		x		Mr. RAMSTAD.....		x	
Mr. EMANUEL.....				Mr. ENGLISH	x		
Mr. BECERRA.....		x		Mr. HULSHOF.....	x		
Mr. POMEROY.....		x					
Ms. TUBBS JONES...		x					
Mr. KIND.....		x					

An amendment by Mr. Johnson to extend the January 1, 2008 effective of the legislation by substituting the language from S. 558. Meaning the effective date would then begin on or after January 1 of the first calendar year that begins no more than 1 year after the date of enactment was defeated by a roll call vote of 3 yeas to 9 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....		x		Mr. CAMP.....	x		
Mr. DOGGET.....		x		Mr. JOHNSON.....	x		
Mr. THOMPSON.....		x		Mr. RAMSTAD.....		x	
Mr. EMANUEL.....				Mr. ENGLISH		x	
Mr. BECERRA.....		x		Mr. HULSHOF.....	x		
Mr. POMEROY.....		x					
Ms. TUBBS JONES...		x					
Mr. KIND.....		x					

An amendment by Mr. Hulshof to strike subparagraph A of section 4(d) and replace it with language allowing mental health or substance-related disorder benefits to not be defined by DSM-IV, and instead by the group health plan and when applicable, State law was defeated by a roll call vote of 3 yeas to 10 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....		x		Mr. CAMP.....	x		
Mr. DOGGET.....		x		Mr. JOHNSON.....	x		
Mr. THOMPSON.....		x		Mr. RAMSTAD.....		x	
Mr. EMANUEL.....		x		Mr. ENGLISH		x	
Mr. BECERRA.....		x		Mr. HULSHOF.....	x		
Mr. POMEROY.....		x					
Ms. TUBBS JONES...		x					
Mr. KIND.....		x					

An amendment by Mr. Hulshof to include language to protect a group health plan's ability to negotiate separate reimbursement or provider payment rates and service delivery systems for different benefits and allow plans to manage the provision of mental health benefits was defeated by a roll call vote of 4 yeas to 9 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....		x		Mr. CAMP.....	x		
Mr. DOGGET.....		x		Mr. JOHNSON.....	x		
Mr. THOMPSON.....		x		Mr. RAMSTAD.....		x	
Mr. EMANUEL.....		x		Mr. ENGLISH	x		
Mr. BECERRA.....		x		Mr. HULSHOF.....	x		
Mr. POMEROY.....		x					
Ms. TUBBS JONES...		x					
Mr. KIND.....		x					

An amendment by Mr. Camp to strike section 4 and add language from S. 558, the Mental Health Parity Act of 2007 was defeated by a roll call vote of 3 yeas to 10 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. STARK.....		x		Mr. CAMP.....	x		
Mr. DOGGET.....		x		Mr. JOHNSON.....	x		
Mr. THOMPSON....		x		Mr. RAMSTAD.....		x	
Mr. EMANUEL.....		x		Mr. ENGLISH		x	
Mr. BECERRA.....		x		Mr. HULSHOF.....	x		
Mr. POMEROY.....		x					
Ms. TUBBS JONES...		x					
Mr. KIND.....		x					

[COMMITTEE PRINT]

[Showing H.R. 1424 As Reported on September 19, 2007, by
the Subcommittee on Health]

110TH CONGRESS
1ST SESSION

H. R. 1424

To amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 9, 2007

Mr. KENNEDY (for himself, Mr. RAMSTAD, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ALEXANDER, Mr. ALLEN, Mr. ANDREWS, Mr. ARCURI, Mr. BACA, Mr. BACHUS, Mr. BAIRD, Ms. BALDWIN, Mr. BARROW, Ms. BEAN, Mr. BECERRA, Ms. BERKLEY, Mr. BERMAN, Mr. BERRY, Mr. BISHOP of Georgia, Mr. BISHOP of New York, Mr. BLUMENAUER, Ms. BORDALLO, Mr. BOREN, Mr. BOSWELL, Mr. BOUCHER, Mr. BOYD of Florida, Mr. BRADY of Pennsylvania, Mr. BRALEY of Iowa, Ms. CORRINE BROWN of Florida, Mr. BUTTERFIELD, Mrs. CAPPs, Mr. CAPUANO, Mr. CARDOZA, Mr. CARNAHAN, Mr. CARNEY, Ms. CARSON, Ms. CASTOR, Mr. CHANDLER, Mrs. CHRISTENSEN, Ms. CLARKE, Mr. CLAY, Mr. CLEAVER, Mr. CLYBURN, Mr. COHEN, Mr. CONYERS, Mr. COOPER, Mr. COSTA, Mr. COSTELLO, Mr. COURTNEY, Mr. CROWLEY, Mrs. CUBIN, Mr. CUELLAR, Mr. CUMMINGS, Mr. DAVIS of Alabama, Mr. DAVIS of Illinois, Mrs. DAVIS of California, Mr. LINCOLN DAVIS of Tennessee, Mr. DEFazio, Ms. DEGETTE, Mr. DELAHUNT, Ms. DELAURO, Mr. DICKS, Mr. DOGGETT, Mr. DONNELLY, Mr. DOYLE, Mr. EDWARDS, Mr. ELLISON, Mr. ELLSWORTH, Mr. EMANUEL, Mrs. EMERSON, Mr. ENGEL, Mr. ENGLISH of Pennsylvania, Ms. ESHOO, Mr. ETHERIDGE, Mr. FALEOMAVAEGA, Mr. FARR, Mr. FATAH, Mr. FERGUSON, Mr. FILNER, Mr. FRANK of Massachusetts, Mr. FRELINGHUYSEN, Ms. GIFFORDS, Mr.

GILCREST, Mrs. GILLIBRAND, Mr. GONZALEZ, Mr. GORDON of Tennessee, Mr. AL GREEN of Texas, Mr. GENE GREEN of Texas, Mr. GRIJALVA, Mr. GUTIERREZ, Mr. HALL of New York, Mr. HARE, Ms. HARMAN, Mr. HASTINGS of Florida, Ms. HERSETH, Mr. HIGGINS, Mr. HINCHEY, Mr. HINOJOSA, Ms. HIRONO, Mr. HODES, Mr. HOLDEN, Mr. HOLT, Mr. HONDA, Ms. HOOLEY, Mr. HOYER, Mr. INSLEE, Mr. ISRAEL, Mr. JACKSON of Illinois, Ms. JACKSON-LEE of Texas, Mr. JEFFERSON, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSON of Georgia, Mrs. JONES of Ohio, Mr. KAGEN, Mr. KANJORSKI, Ms. KAPTUR, Mr. KELLER of Florida, Mr. KILDEE, Ms. KILPATRICK, Mr. KIND, Mr. KING of New York, Mr. KIRK, Mr. KLEIN of Florida, Mr. KUCINICH, Mr. LAHOOD, Mr. LAMPSON, Mr. LANGEVIN, Mr. LANTOS, Mr. LARSEN of Washington, Mr. LARSON of Connecticut, Mr. LATOURETTE, Ms. LEE, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LIPINSKI, Mr. LOBIONDO, Mr. LOEBSACK, Ms. ZOE LOFGREN of California, Mrs. LOWEY, Mr. LYNCH, Mrs. MALONEY of New York, Mr. MARKEY, Mr. MARSHALL, Mr. MATHESON, Ms. MATSUI, Mrs. MCCARTHY of New York, Ms. MCCOLLUM of Minnesota, Mr. McDERMOTT, Mr. MCGOVERN, Mr. MCHUGH, Mr. MCINTYRE, Mr. MCNERNEY, Mr. MCNULTY, Mr. MEEHAN, Mr. MEEK of Florida, Mr. MEEKS of New York, Mr. MICA, Mr. MICHAUD, Ms. MILLENDER-MCDONALD, Mr. GEORGE MILLER of California, Mr. MOLLOHAN, Mr. MOORE of Kansas, Ms. MOORE of Wisconsin, Mr. MORAN of Virginia, Mr. MURPHY of Connecticut, Mr. TIM MURPHY of Pennsylvania, Mr. MURTHA, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEAL of Massachusetts, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OLVER, Mr. ORTIZ, Mr. PALLONE, Mr. PASCRELL, Mr. PASTOR, Mr. PAYNE, Mr. PERLMUTTER, Mr. PETERSON of Minnesota, Mr. PICKERING, Mr. PLATTS, Mr. POMEROY, Mr. PRICE of North Carolina, Mr. RAHALL, Mr. RANGEL, Mr. RENZI, Mr. REYES, Mr. RODRIGUEZ, Ms. ROS-LEHTINEN, Mr. ROSS, Mr. ROTHMAN, Ms. ROYBAL-ALLARD, Mr. RUPPERSBERGER, Mr. RUSH, Mr. RYAN of Ohio, Mr. SALAZAR, Ms. LINDA T. SANCHEZ of California, Ms. LORETTA SANCHEZ of California, Mr. SARBANES, Mr. SAXTON, Ms. SCHAKOWSKY, Mr. SCHIFF, Mrs. SCHMIDT, Ms. WASSERMAN SCHULTZ, Ms. SCHWARTZ, Mr. SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SESTAK, Mr. SHAYS, Ms. SHEAPORTER, Mr. SHERMAN, Mr. SIRES, Mr. SKELTON, Ms. SLAUGHTER, Mr. SMITH of Washington, Mr. SMITH of New Jersey, Mr. SNYDER, Ms. SOLIS, Mr. SPACE, Mr. SPRATT, Mr. STARK, Mr. STUPAK, Mr. SULLIVAN, Ms. SUTTON, Mr. TANNER, Mrs. TAUSCHER, Mr. THOMPSON of Mississippi, Mr. THOMPSON of California, Mr. TIERNEY, Mr. TOWNS, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. UPTON, Mr. VAN HOLLEN, Ms. VELÁZQUEZ, Mr. VISCLOSKEY, Mr. WALSH of New York, Mr. WALZ of Minnesota, Mr. WAMP, Ms. WATERS, Ms. WATSON, Mr. WATT, Mr. WAXMAN, Mr. WEINER, Mr. WELCH of Vermont, Mr. WEXLER, Mr. WILSON of Ohio, Mr. WILSON of South Carolina, Ms. WOOLSEY, Mr. WU, Mr. WYNN, Mr. YARMUTH, and Mr. YOUNG of Alaska) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

SEPTEMBER 19, 2007

[Strike out all after the enacting clause and insert the part printed in roman]

[For text of introduced bill, see copy of bill as introduced on March 9, 2007]

A BILL

To amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

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

3 **SEC. 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Paul Wellstone Mental Health and Addiction Equity Act
6 of 2007”.

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

Sec. 1. Short title; table of contents.

Sec. 2. Amendments to the Employee Retirement Income Security Act of 1974.

Sec. 3. Amendments to the Public Health Service Act relating to the group
market.

Sec. 4. Amendments to the Internal Revenue Code of 1986.

Sec. 5. Government Accountability Office studies and reports.

9 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**
10 **COME SECURITY ACT OF 1974.**

11 (a) **EXTENSION OF PARITY TO TREATMENT LIMITS**
12 **AND BENEFICIARY FINANCIAL REQUIREMENTS.**—Section

1 712 of the Employee Retirement Income Security Act of
2 1974 (29 U.S.C. 1185a) is amended—

3 (1) in subsection (a), by adding at the end the
4 following new paragraphs:

5 “(3) TREATMENT LIMITS.—

6 “(A) NO TREATMENT LIMIT.—If the plan
7 or coverage does not include a treatment limit
8 (as defined in subparagraph (D)) on substan-
9 tially all medical and surgical benefits in any
10 category of items or services, the plan or cov-
11 erage may not impose any treatment limit on
12 mental health and substance-related disorder
13 benefits that are classified in the same category
14 of items or services.

15 “(B) TREATMENT LIMIT.—If the plan or
16 coverage includes a treatment limit on substan-
17 tially all medical and surgical benefits in any
18 category of items or services, the plan or cov-
19 erage may not impose such a treatment limit on
20 mental health and substance-related disorder
21 benefits for items and services within such cat-
22 egory that are more restrictive than the pre-
23 dominant treatment limit that is applicable to
24 medical and surgical benefits for items and
25 services within such category.

1 “(C) CATEGORIES OF ITEMS AND SERV-
2 ICES FOR APPLICATION OF TREATMENT LIMITS
3 AND BENEFICIARY FINANCIAL REQUIRE-
4 MENTS.—For purposes of this paragraph and
5 paragraph (4), there shall be the following four
6 categories of items and services for benefits,
7 whether medical and surgical benefits or mental
8 health and substance-related disorder benefits,
9 and all medical and surgical benefits and all
10 mental health and substance related benefits
11 shall be classified into one of the following cat-
12 egories:

13 “(i) INPATIENT, IN-NETWORK.—Items
14 and services furnished on an inpatient
15 basis and within a network of providers es-
16 tablished or recognized under such plan or
17 coverage.

18 “(ii) INPATIENT, OUT-OF-NETWORK.—
19 Items and services furnished on an inpa-
20 tient basis and outside any network of pro-
21 viders established or recognized under such
22 plan or coverage.

23 “(iii) OUTPATIENT, IN-NETWORK.—
24 Items and services furnished on an out-
25 patient basis and within a network of pro-

1 viders established or recognized under such
2 plan or coverage.

3 “(iv) OUTPATIENT, OUT-OF-NET-
4 WORK.—Items and services furnished on
5 an outpatient basis and outside any net-
6 work of providers established or recognized
7 under such plan or coverage.

8 “(D) TREATMENT LIMIT DEFINED.—For
9 purposes of this paragraph, the term ‘treatment
10 limit’ means, with respect to a plan or coverage,
11 limitation on the frequency of treatment, num-
12 ber of visits or days of coverage, or other simi-
13 lar limit on the duration or scope of treatment
14 under the plan or coverage.

15 “(E) PREDOMINANCE.—For purposes of
16 this subsection, a treatment limit or financial
17 requirement with respect to a category of items
18 and services is considered to be predominant if
19 it is the most common or frequent of such type
20 of limit or requirement with respect to such cat-
21 egory of items and services.

22 “(4) BENEFICIARY FINANCIAL REQUIRE-
23 MENTS.—

24 “(A) NO BENEFICIARY FINANCIAL RE-
25 QUIREMENT.—If the plan or coverage does not

1 include a beneficiary financial requirement (as
2 defined in subparagraph (C)) on substantially
3 all medical and surgical benefits within a cat-
4 egory of items and services (specified under
5 paragraph (3)(C)), the plan or coverage may
6 not impose such a beneficiary financial require-
7 ment on mental health and substance-related
8 disorder benefits for items and services within
9 such category.

10 “(B) BENEFICIARY FINANCIAL REQUIRE-
11 MENT.—

12 “(i) TREATMENT OF DEDUCTIBLES,
13 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
14 NANCIAL REQUIREMENTS.—If the plan or
15 coverage includes a deductible, a limitation
16 on out-of-pocket expenses, or similar bene-
17 ficiary financial requirement that does not
18 apply separately to individual items and
19 services on substantially all medical and
20 surgical benefits within a category of items
21 and services (as specified in paragraph
22 (3)(C)), the plan or coverage shall apply
23 such requirement (or, if there is more than
24 one such requirement for such category of
25 items and services, the predominant re-

1 requirement for such category) both to med-
2 ical and surgical benefits within such cat-
3 egory and to mental health and substance-
4 related disorder benefits within such cat-
5 egory and shall not distinguish in the ap-
6 plication of such requirement between such
7 medical and surgical benefits and such
8 mental health and substance-related dis-
9 order benefits.

10 “(ii) OTHER FINANCIAL REQUIRE-
11 MENTS.—If the plan or coverage includes a
12 beneficiary financial requirement not de-
13 scribed in clause (i) on substantially all
14 medical and surgical benefits within a cat-
15 egory of items and services, the plan or
16 coverage may not impose such financial re-
17 quirement on mental health and substance-
18 related disorder benefits for items and
19 services within such category in a way that
20 is more costly to the participant or bene-
21 ficiary than the predominant beneficiary fi-
22 nancial requirement applicable to medical
23 and surgical benefits for items and services
24 within such category.

1 “(C) BENEFICIARY FINANCIAL REQUIRE-
2 MENT DEFINED.—For purposes of this para-
3 graph, the term ‘beneficiary financial require-
4 ment’ includes, with respect to a plan or cov-
5 erage, any deductible, coinsurance, co-payment,
6 other cost sharing, and limitation on the total
7 amount that may be paid by a participant or
8 beneficiary with respect to benefits under the
9 plan or coverage, but does not include the appli-
10 cation of any aggregate lifetime limit or annual
11 limit.”; and

12 (2) in subsection (b)—

13 (A) by striking “construed—” and all that
14 follows through “(1) as requiring” and insert-
15 ing “construed as requiring”;

16 (B) by striking “; or” and inserting a pe-
17 riod; and

18 (C) by striking paragraph (2).

19 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
20 BENEFITS AND REVISION OF DEFINITION.—Such section
21 is further amended—

22 (1) by striking “mental health benefits” and in-
23 serting “mental health and substance-related dis-
24 order benefits” each place it appears; and

25 (2) in paragraph (4) of subsection (e)—

1 (A) by striking “MENTAL HEALTH BENE-
2 FITS” and inserting “MENTAL HEALTH AND
3 SUBSTANCE-RELATED DISORDER BENEFITS”;

4 (B) by striking “benefits with respect to
5 mental health services” and inserting “benefits
6 with respect to services for mental health condi-
7 tions or substance-related disorders”; and

8 (C) by striking “, but does not include
9 benefits with respect to treatment of substances
10 abuse or chemical dependency”.

11 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
12 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
13 such section, as amended by subsection (a)(1), is further
14 amended by adding at the end the following new para-
15 graph:

16 “(5) AVAILABILITY OF PLAN INFORMATION.—
17 The criteria for medical necessity determinations
18 made under the plan with respect to mental health
19 and substance-related disorder benefits (or the
20 health insurance coverage offered in connection with
21 the plan with respect to such benefits) shall be made
22 available by the plan administrator (or the health in-
23 surance issuer offering such coverage) to any cur-
24 rent or potential participant, beneficiary, or con-
25 tracting provider upon request. The reason for any

1 denial under the plan (or coverage) of reimburse-
2 ment or payment for services with respect to mental
3 health and substance-related disorder benefits in the
4 case of any participant or beneficiary shall, upon re-
5 quest, be made available by the plan administrator
6 (or the health insurance issuer offering such cov-
7 erage) to the participant or beneficiary.”.

8 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
9 section (a) of such section is further amended by adding
10 at the end the following new paragraph:

11 “(6) MINIMUM SCOPE OF COVERAGE AND EQ-
12 UITY IN OUT-OF-NETWORK BENEFITS.—

13 “(A) MINIMUM SCOPE OF MENTAL
14 HEALTH AND SUBSTANCE-RELATED DISORDER
15 BENEFITS.—In the case of a group health plan
16 (or health insurance coverage offered in connec-
17 tion with such a plan) that provides any mental
18 health and substance-related disorder benefits,
19 the plan or coverage shall include benefits for
20 any mental health condition or substance-re-
21 lated disorder for which benefits are provided
22 under the benefit plan option offered under
23 chapter 89 of title 5, United States Code, with
24 the highest average enrollment as of the begin-

1 ning of the most recent year beginning on or
2 before the beginning of the plan year involved.

3 “(B) EQUITY IN COVERAGE OF OUT-OF-
4 NETWORK BENEFITS.—

5 “(i) IN GENERAL.—In the case of a
6 plan or coverage that provides both med-
7 ical and surgical benefits and mental
8 health and substance-related disorder bene-
9 fits, if medical and surgical benefits are
10 provided for substantially all items and
11 services in a category specified in clause
12 (ii) furnished outside any network of pro-
13 viders established or recognized under such
14 plan or coverage, the mental health and
15 substance-related disorder benefits shall
16 also be provided for items and services in
17 such category furnished outside any net-
18 work of providers established or recognized
19 under such plan or coverage in accordance
20 with the requirements of this section.

21 “(ii) CATEGORIES OF ITEMS AND
22 SERVICES.—For purposes of clause (i),
23 there shall be the following three categories
24 of items and services for benefits, whether
25 medical and surgical benefits or mental

1 health and substance-related disorder bene-
2 fits, and all medical and surgical benefits
3 and all mental health and substance-re-
4 lated disorder benefits shall be classified
5 into one of the following categories:

6 “(I) EMERGENCY.—Items and
7 services, whether furnished on an in-
8 patient or outpatient basis, required
9 for the treatment of an emergency
10 medical condition (including an emer-
11 gency condition relating to mental
12 health and substance-related dis-
13 orders).

14 “(II) INPATIENT.—Items and
15 services not described in subclause (I)
16 furnished on an inpatient basis.

17 “(III) OUTPATIENT.—Items and
18 services not described in subclause (I)
19 furnished on an outpatient basis.”.

20 (e) REVISION OF INCREASED COST EXEMPTION.—
21 Paragraph (2) of subsection (c) of such section is amended
22 to read as follows:

23 “(2) INCREASED COST EXEMPTION.—

24 “(A) IN GENERAL.—With respect to a
25 group health plan (or health insurance coverage

1 offered in connection with such a plan), if the
2 application of this section to such plan (or cov-
3 erage) results in an increase for the plan year
4 involved of the actual total costs of coverage
5 with respect to medical and surgical benefits
6 and mental health and substance-related dis-
7 order benefits under the plan (as determined
8 and certified under subparagraph (C)) by an
9 amount that exceeds the applicable percentage
10 described in subparagraph (B) of the actual
11 total plan costs, the provisions of this section
12 shall not apply to such plan (or coverage) dur-
13 ing the following plan year, and such exemption
14 shall apply to the plan (or coverage) for 1 plan
15 year.

16 “(B) APPLICABLE PERCENTAGE.—With re-
17 spect to a plan (or coverage), the applicable
18 percentage described in this paragraph shall
19 be—

20 “(i) 2 percent in the case of the first
21 plan year which begins after the date of
22 the enactment of the Paul Wellstone Men-
23 tal Health and Addiction Equity Act of
24 2007; and

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

3 “(C) DETERMINATIONS BY ACTUARIES.—
4 Determinations as to increases in actual costs
5 under a plan (or coverage) for purposes of this
6 subsection shall be made by a qualified actuary
7 who is a member in good standing of the Amer-
8 ican Academy of Actuaries. Such determina-
9 tions shall be certified by the actuary and be
10 made available to the general public.

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

19 “(E) NOTIFICATION.—An election to mod-
20 ify coverage of mental health and substance-re-
21 lated disorder benefits as permitted under this
22 paragraph shall be treated as a material modi-
23 fication in the terms of the plan as described in
24 section 102(a)(1) and shall be subject to the

1 applicable notice requirements under section
2 104(b)(1).”.

3 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
4 ERS.—Subsection (c)(1)(B) of such section is amended—

5 (1) by inserting “(or 1 in the case of an em-
6 ployer residing in a State that permits small groups
7 to include a single individual)” after “at least 2” the
8 first place it appears; and

9 (2) by striking “and who employs at least 2 em-
10 ployees on the first day of the plan year”.

11 (g) ELIMINATION OF SUNSET PROVISION.—Such sec-
12 tion is amended by striking out subsection (f).

13 (h) CLARIFICATION REGARDING PREEMPTION.—
14 Such section is further amended by inserting after sub-
15 section (e) the following new subsection:

16 “(f) PREEMPTION, RELATION TO STATE LAWS.—
17 “(1) IN GENERAL.—Nothing in this section
18 shall be construed to preempt any State law that
19 provides greater consumer protections, benefits,
20 methods of access to benefits, rights or remedies
21 that are greater than the protections, benefits, meth-
22 ods of access to benefits, rights or remedies provided
23 under this section.

1 “(2) ERISA.—Nothing in this section shall be
2 construed to affect or modify the provisions of sec-
3 tion 514 with respect to group health plans.”.

4 (i) CONFORMING AMENDMENTS TO HEADING.—

5 (1) IN GENERAL.—The heading of such section
6 is amended to read as follows:

7 **“SEC. 712.”.**

8 (2) CLERICAL AMENDMENT.—The table of con-
9 tents in section 1 of such Act is amended by striking
10 the item relating to section 712 and inserting the
11 following new item:

“Sec. 712. Equity in mental health and substance-related disorder benefits.”.

12 (j) EFFECTIVE DATE.—The amendments made by
13 this section shall apply with respect to plan years begin-
14 ning on or after January 1, 2008.

15 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
16 **ACT RELATING TO THE GROUP MARKET.**

17 (a) EXTENSION OF PARITY TO TREATMENT LIMITS
18 AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section
19 2705 of the Public Health Service Act (42 U.S.C. 300gg–
20 5) is amended—

21 (1) in subsection (a), by adding at the end the
22 following new paragraphs:

23 “(3) TREATMENT LIMITS.—

24 “(A) NO TREATMENT LIMIT.—If the plan
25 or coverage does not include a treatment limit

1 (as defined in subparagraph (D)) on substan-
2 tially all medical and surgical benefits in any
3 category of items or services (specified in sub-
4 paragraph (C)), the plan or coverage may not
5 impose any treatment limit on mental health
6 and substance-related disorder benefits that are
7 classified in the same category of items or serv-
8 ices.

9 “(B) TREATMENT LIMIT.—If the plan or
10 coverage includes a treatment limit on substan-
11 tially all medical and surgical benefits in any
12 category of items or services, the plan or cov-
13 erage may not impose such a treatment limit on
14 mental health and substance-related disorder
15 benefits for items and services within such cat-
16 egory that are more restrictive than the pre-
17 dominant treatment limit that is applicable to
18 medical and surgical benefits for items and
19 services within such category.

20 “(C) CATEGORIES OF ITEMS AND SERV-
21 ICES FOR APPLICATION OF TREATMENT LIMITS
22 AND BENEFICIARY FINANCIAL REQUIRE-
23 MENTS.—For purposes of this paragraph and
24 paragraph (4), there shall be the following four
25 categories of items and services for benefits,

1 whether medical and surgical benefits or mental
2 health and substance-related disorder benefits,
3 and all medical and surgical benefits and all
4 mental health and substance related benefits
5 shall be classified into one of the following cat-
6 egories:

7 “(i) INPATIENT, IN-NETWORK.—Items
8 and services furnished on an inpatient
9 basis and within a network of providers es-
10 tablished or recognized under such plan or
11 coverage.

12 “(ii) INPATIENT, OUT-OF-NETWORK.—
13 Items and services furnished on an inpa-
14 tient basis and outside any network of pro-
15 viders established or recognized under such
16 plan or coverage.

17 “(iii) OUTPATIENT, IN-NETWORK.—
18 Items and services furnished on an out-
19 patient basis and within a network of pro-
20 viders established or recognized under such
21 plan or coverage.

22 “(iv) OUTPATIENT, OUT-OF-NET-
23 WORK.—Items and services furnished on
24 an outpatient basis and outside any net-

1 work of providers established or recognized
2 under such plan or coverage.

3 “(D) TREATMENT LIMIT DEFINED.—For
4 purposes of this paragraph, the term ‘treatment
5 limit’ means, with respect to a plan or coverage,
6 limitation on the frequency of treatment, num-
7 ber of visits or days of coverage, or other simi-
8 lar limit on the duration or scope of treatment
9 under the plan or coverage.

10 “(E) PREDOMINANCE.—For purposes of
11 this subsection, a treatment limit or financial
12 requirement with respect to a category of items
13 and services is considered to be predominant if
14 it is the most common or frequent of such type
15 of limit or requirement with respect to such cat-
16 egory of items and services.

17 “(4) BENEFICIARY FINANCIAL REQUIRE-
18 MENTS.—

19 “(A) NO BENEFICIARY FINANCIAL RE-
20 QUIREMENT.—If the plan or coverage does not
21 include a beneficiary financial requirement (as
22 defined in subparagraph (C)) on substantially
23 all medical and surgical benefits within a cat-
24 egory of items and services (specified in para-
25 graph (3)(C)), the plan or coverage may not im-

1 pose such a beneficiary financial requirement on
2 mental health and substance-related disorder
3 benefits for items and services within such cat-
4 egory.

5 “(B) BENEFICIARY FINANCIAL REQUIRE-
6 MENT.—

7 “(i) TREATMENT OF DEDUCTIBLES,
8 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
9 NANCIAL REQUIREMENTS.—If the plan or
10 coverage includes a deductible, a limitation
11 on out-of-pocket expenses, or similar bene-
12 ficiary financial requirement that does not
13 apply separately to individual items and
14 services on substantially all medical and
15 surgical benefits within a category of items
16 and services, the plan or coverage shall
17 apply such requirement (or, if there is
18 more than one such requirement for such
19 category of items and services, the pre-
20 dominant requirement for such category)
21 both to medical and surgical benefits with-
22 in such category and to mental health and
23 substance-related disorder benefits within
24 such category and shall not distinguish in
25 the application of such requirement be-

1 tween such medical and surgical benefits
2 and such mental health and substance-re-
3 lated disorder benefits.

4 “(ii) OTHER FINANCIAL REQUIRE-
5 MENTS.—If the plan or coverage includes a
6 beneficiary financial requirement not de-
7 scribed in clause (i) on substantially all
8 medical and surgical benefits within a cat-
9 egory of items and services, the plan or
10 coverage may not impose such financial re-
11 quirement on mental health and substance-
12 related disorder benefits for items and
13 services within such category in a way that
14 is more costly to the participant or bene-
15 ficiary than the predominant beneficiary fi-
16 nancial requirement applicable to medical
17 and surgical benefits for items and services
18 within such category.

19 “(C) BENEFICIARY FINANCIAL REQUIRE-
20 MENT DEFINED.—For purposes of this para-
21 graph, the term ‘beneficiary financial require-
22 ment’ includes, with respect to a plan or cov-
23 erage, any deductible, coinsurance, co-payment,
24 other cost sharing, and limitation on the total
25 amount that may be paid by a participant or

1 beneficiary with respect to benefits under the
2 plan or coverage, but does not include the appli-
3 cation of any aggregate lifetime limit or annual
4 limit.”; and

5 (2) in subsection (b)—

6 (A) by striking “construed—” and all that
7 follows through “(1) as requiring” and insert-
8 ing “construed as requiring”;

9 (B) by striking “; or” and inserting a pe-
10 riod; and

11 (C) by striking paragraph (2).

12 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
13 BENEFITS AND REVISION OF DEFINITION.—Such section
14 is further amended—

15 (1) by striking “mental health benefits” and in-
16 serting “mental health and substance-related dis-
17 order benefits” each place it appears; and

18 (2) in paragraph (4) of subsection (e)—

19 (A) by striking “MENTAL HEALTH BENE-
20 FITS” and inserting “MENTAL HEALTH AND
21 SUBSTANCE-RELATED DISORDER BENEFITS”;

22 (B) by striking “benefits with respect to
23 mental health services” and inserting “benefits
24 with respect to services for mental health condi-
25 tions or substance-related disorders”; and

1 (C) by striking “, but does not include
2 benefits with respect to treatment of substances
3 abuse or chemical dependency”.

4 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
5 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
6 such section, as amended by subsection (a)(1), is further
7 amended by adding at the end the following new para-
8 graph:

9 “(5) AVAILABILITY OF PLAN INFORMATION.—
10 The criteria for medical necessity determinations
11 made under the plan with respect to mental health
12 and substance-related disorder benefits (or the
13 health insurance coverage offered in connection with
14 the plan with respect to such benefits) shall be made
15 available by the plan administrator (or the health in-
16 surance issuer offering such coverage) to any cur-
17 rent or potential participant, beneficiary, or con-
18 tracting provider upon request. The reason for any
19 denial under the plan (or coverage) of reimburse-
20 ment or payment for services with respect to mental
21 health and substance-related disorder benefits in the
22 case of any participant or beneficiary shall, upon re-
23 quest, be made available by the plan administrator
24 (or the health insurance issuer offering such cov-
25 erage) to the participant or beneficiary.”

1 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
2 section (a) of such section is further amended by adding
3 at the end the following new paragraph:

4 “(6) MINIMUM SCOPE OF COVERAGE AND EQ-
5 UITY IN OUT-OF-NETWORK BENEFITS.—

6 “(A) MINIMUM SCOPE OF MENTAL
7 HEALTH AND SUBSTANCE-RELATED DISORDER
8 BENEFITS.—In the case of a group health plan
9 (or health insurance coverage offered in connec-
10 tion with such a plan) that provides any mental
11 health and substance-related disorder benefits,
12 the plan or coverage shall include benefits for
13 any mental health condition or substance-re-
14 lated disorder for which benefits are provided
15 under the benefit plan option offered under
16 chapter 89 of title 5, United States Code, with
17 the highest average enrollment as of the begin-
18 ning of the most recent year beginning on or
19 before the beginning of the plan year involved.

20 “(B) EQUITY IN COVERAGE OF OUT-OF-
21 NETWORK BENEFITS.—

22 “(i) IN GENERAL.—In the case of a
23 plan or coverage that provides both med-
24 ical and surgical benefits and mental
25 health and substance-related disorder bene-

1 fits, if medical and surgical benefits are
2 provided for substantially all items and
3 services in a category specified in clause
4 (ii) furnished outside any network of pro-
5 viders established or recognized under such
6 plan or coverage, the mental health and
7 substance-related disorder benefits shall
8 also be provided for items and services in
9 such category furnished outside any net-
10 work of providers established or recognized
11 under such plan or coverage in accordance
12 with the requirements of this section.

13 “(ii) CATEGORIES OF ITEMS AND
14 SERVICES.—For purposes of clause (i),
15 there shall be the following three categories
16 of items and services for benefits, whether
17 medical and surgical benefits or mental
18 health and substance-related disorder bene-
19 fits, and all medical and surgical benefits
20 and all mental health and substance-re-
21 lated disorder benefits shall be classified
22 into one of the following categories:

23 “(I) EMERGENCY.—Items and
24 services, whether furnished on an in-
25 patient or outpatient basis, required

1 for the treatment of an emergency
2 medical condition (including an emer-
3 gency condition relating to mental
4 health and substance-related dis-
5 orders).

6 “(II) INPATIENT.—Items and
7 services not described in subclause (I)
8 furnished on an inpatient basis.

9 “(III) OUTPATIENT.—Items and
10 services not described in subclause (I)
11 furnished on an outpatient basis.”

12 (e) REVISION OF INCREASED COST EXEMPTION.—
13 Paragraph (2) of subsection (c) of such section is amended
14 to read as follows:

15 “(2) INCREASED COST EXEMPTION.—

16 “(A) IN GENERAL.—With respect to a
17 group health plan (or health insurance coverage
18 offered in connection with such a plan), if the
19 application of this section to such plan (or cov-
20 erage) results in an increase for the plan year
21 involved of the actual total costs of coverage
22 with respect to medical and surgical benefits
23 and mental health and substance-related dis-
24 order benefits under the plan (as determined
25 and certified under subparagraph (C)) by an

1 amount that exceeds the applicable percentage
2 described in subparagraph (B) of the actual
3 total plan costs, the provisions of this section
4 shall not apply to such plan (or coverage) dur-
5 ing the following plan year, and such exemption
6 shall apply to the plan (or coverage) for 1 plan
7 year.

8 “(B) APPLICABLE PERCENTAGE.—With re-
9 spect to a plan (or coverage), the applicable
10 percentage described in this paragraph shall
11 be—

12 “(i) 2 percent in the case of the first
13 plan year which begins after the date of
14 the enactment of the Paul Wellstone Men-
15 tal Health and Addiction Equity Act of
16 2007; and

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

19 “(C) DETERMINATIONS BY ACTUARIES.—
20 Determinations as to increases in actual costs
21 under a plan (or coverage) for purposes of this
22 subsection shall be made by a qualified actuary
23 who is a member in good standing of the Amer-
24 ican Academy of Actuaries. Such determina-

1 tions shall be certified by the actuary and be
2 made available to the general public.

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

11 “(E) NOTIFICATION.—A group health plan
12 under this part shall comply with the notice re-
13 quirement under section 712(c)(2)(E) of the
14 Employee Retirement Income Security Act of
15 1974 with respect to the a modification of men-
16 tal health and substance-related disorder bene-
17 fits as permitted under this paragraph as if
18 such section applied to such plan.”.

19 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
20 ERS.—Subsection (c)(1)(B) of such section is amended—

21 (1) by inserting “(or 1 in the case of an em-
22 ployer residing in a State that permits small groups
23 to include a single individual)” after “at least 2” the
24 first place it appears; and

1 (2) by striking “and who employs at least 2 em-
2 ployees on the first day of the plan year”.

3 (g) ELIMINATION OF SUNSET PROVISION.—Such sec-
4 tion is amended by striking out subsection (f).

5 (h) CLARIFICATION REGARDING PREEMPTION.—
6 Such section is further amended by inserting after sub-
7 section (e) the following new subsection:

8 “(f) PREEMPTION, RELATION TO STATE LAWS.—

9 “(1) IN GENERAL.—Nothing in this section
10 shall be construed to preempt any State law that
11 provides greater consumer protections, benefits,
12 methods of access to benefits, rights or remedies
13 that are greater than the protections, benefits, meth-
14 ods of access to benefits, rights or remedies provided
15 under this section.

16 “(2) CONSTRUCTION.—Nothing in this section
17 shall be construed to affect or modify the provisions
18 of section 2723 with respect to group health plans.”.

19 (i) CONFORMING AMENDMENT TO HEADING.—The
20 heading of such section is amended to read as follows:

21 “SEC. 2705.”.

22 (j) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to plan years begin-
24 ning on or after January 1, 2008.

1 **SEC. 4. AMENDMENTS TO THE INTERNAL REVENUE CODE**
2 **OF 1986.**

3 (a) **EXTENSION OF PARITY TO TREATMENT LIMITS**
4 **AND BENEFICIARY FINANCIAL REQUIREMENTS.**—Section
5 9812 of the Internal Revenue Code of 1986 is amended—

6 (1) in subsection (a), by adding at the end the
7 following new paragraphs:

8 “(3) **TREATMENT LIMITS.**—In the case of a
9 group health plan that provides both medical and
10 surgical benefits and mental health or substance-re-
11 lated disorder benefits—

12 “(A) **NO TREATMENT LIMIT.**—If the plan
13 does not include a treatment limit (as defined
14 in subparagraph (D)) on substantially all med-
15 ical and surgical benefits in any category of
16 items or services (specified in subparagraph
17 (C)), the plan may not impose any treatment
18 limit on mental health or substance-related dis-
19 order benefits that are classified in the same
20 category of items or services.

21 “(B) **TREATMENT LIMIT.**—If the plan in-
22 cludes a treatment limit on substantially all
23 medical and surgical benefits in any category of
24 items or services, the plan may not impose such
25 a treatment limit on mental health or sub-
26 stance-related disorder benefits for items and

1 services within such category that is more re-
2 strictive than the predominant treatment limit
3 that is applicable to medical and surgical bene-
4 fits for items and services within such category.

5 “(C) CATEGORIES OF ITEMS AND SERV-
6 ICES FOR APPLICATION OF TREATMENT LIMITS
7 AND BENEFICIARY FINANCIAL REQUIRE-
8 MENTS.—For purposes of this paragraph and
9 paragraph (4), there shall be the following five
10 categories of items and services for benefits,
11 whether medical and surgical benefits or mental
12 health and substance-related disorder benefits,
13 and all medical and surgical benefits and all
14 mental health and substance related benefits
15 shall be classified into one of the following cat-
16 egories:

17 “(i) INPATIENT, IN-NETWORK.—Items
18 and services not described in clause (v)
19 furnished on an inpatient basis and within
20 a network of providers established or rec-
21 ognized under such plan.

22 “(ii) INPATIENT, OUT-OF-NETWORK.—
23 Items and services not described in clause
24 (v) furnished on an inpatient basis and

1 outside any network of providers estab-
2 lished or recognized under such plan.

3 “(iii) OUTPATIENT, IN-NETWORK.—
4 Items and services not described in clause
5 (v) furnished on an outpatient basis and
6 within a network of providers established
7 or recognized under such plan.

8 “(iv) OUTPATIENT, OUT-OF-NET-
9 WORK.—Items and services not described
10 in clause (v) furnished on an outpatient
11 basis and outside any network of providers
12 established or recognized under such plan.

13 “(v) EMERGENCY CARE.—Items and
14 services, whether furnished on an inpatient
15 or outpatient basis or within or outside
16 any network of providers, required for the
17 treatment of an emergency medical condi-
18 tion (including an emergency condition re-
19 lating to mental health or substance-re-
20 lated disorders).

21 “(D) TREATMENT LIMIT DEFINED.—For
22 purposes of this paragraph, the term ‘treatment
23 limit’ means, with respect to a plan, limitation
24 on the frequency of treatment, number of visits
25 or days of coverage, or other similar limit on

1 the duration or scope of treatment under the
2 plan.

3 “(E) PREDOMINANCE.—For purposes of
4 this subsection, a treatment limit or financial
5 requirement with respect to a category of items
6 and services is considered to be predominant if
7 it is the most common or frequent of such type
8 of limit or requirement with respect to such cat-
9 egory of items and services.

10 “(4) BENEFICIARY FINANCIAL REQUIRE-
11 MENTS.—In the case of a group health plan that
12 provides both medical and surgical benefits and
13 mental health or substance-related disorder
14 benefits—

15 “(A) NO BENEFICIARY FINANCIAL RE-
16 QUIREMENT.—If the plan does not include a
17 beneficiary financial requirement (as defined in
18 subparagraph (C)) on substantially all medical
19 and surgical benefits within a category of items
20 and services (specified in paragraph (3)(C)),
21 the plan may not impose such a beneficiary fi-
22 nancial requirement on mental health or sub-
23 stance-related disorder benefits for items and
24 services within such category.

1 “(B) BENEFICIARY FINANCIAL REQUIRE-
2 MENT.—

3 “(i) TREATMENT OF DEDUCTIBLES,
4 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
5 NANCIAL REQUIREMENTS.—If the plan in-
6 cludes a deductible, a limitation on out-of-
7 pocket expenses, or similar beneficiary fi-
8 nancial requirement that does not apply
9 separately to individual items and services
10 on substantially all medical and surgical
11 benefits within a category of items and
12 services, the plan shall apply such require-
13 ment (or, if there is more than one such
14 requirement for such category of items and
15 services, the predominant requirement for
16 such category) both to medical and sur-
17 gical benefits within such category and to
18 mental health and substance-related dis-
19 order benefits within such category and
20 shall not distinguish in the application of
21 such requirement between such medical
22 and surgical benefits and such mental
23 health and substance-related disorder bene-
24 fits.

1 “(ii) OTHER FINANCIAL REQUIRE-
2 MENTS.—If the plan includes a beneficiary
3 financial requirement not described in
4 clause (i) on substantially all medical and
5 surgical benefits within a category of items
6 and services, the plan may not impose such
7 financial requirement on mental health or
8 substance-related disorder benefits for
9 items and services within such category in
10 a way that results in greater out-of-pocket
11 expenses to the participant or beneficiary
12 than the predominant beneficiary financial
13 requirement applicable to medical and sur-
14 gical benefits for items and services within
15 such category.

16 “(iii) CONSTRUCTION.—Nothing in
17 this subparagraph shall be construed as
18 prohibiting the plan from waiving the ap-
19 plication of any deductible for mental
20 health benefits or substance-related dis-
21 order benefits or both.

22 “(C) BENEFICIARY FINANCIAL REQUIRE-
23 MENT DEFINED.—For purposes of this para-
24 graph, the term ‘beneficiary financial require-
25 ment’ includes, with respect to a plan, any de-

1 ductible, coinsurance, co-payment, other cost
2 sharing, and limitation on the total amount
3 that may be paid by a participant or beneficiary
4 with respect to benefits under the plan, but
5 does not include the application of any aggre-
6 gate lifetime limit or annual limit.”, and

7 (2) in subsection (b)—

8 (A) by striking “construed—” and all that
9 follows through “(1) as requiring” and insert-
10 ing “construed as requiring”,

11 (B) by striking “; or” and inserting a pe-
12 riod, and

13 (C) by striking paragraph (2).

14 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
15 BENEFITS AND REVISION OF DEFINITION.—Section 9812
16 of such Code is further amended—

17 (1) by striking “mental health benefits” each
18 place it appears (other than in any provision amend-
19 ed by paragraph (2)) and inserting “mental health
20 or substance-related disorder benefits”,

21 (2) by striking “mental health benefits” each
22 place it appears in subsections (a)(1)(B)(i),
23 (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting
24 “mental health and substance-related disorder bene-
25 fits”, and

1 (3) in subsection (e), by striking paragraph (4)
2 and inserting the following new paragraphs:

3 “(4) MENTAL HEALTH BENEFITS.—The term
4 ‘mental health benefits’ means benefits with respect
5 to services for mental health conditions, as defined
6 under the terms of the plan, but does not include
7 substance-related disorder benefits.

8 “(5) SUBSTANCE-RELATED DISORDER BENE-
9 FITS.—The term ‘substance-related disorder bene-
10 fits’ means benefits with respect to services for sub-
11 stance-related disorders, as defined under the terms
12 of the plan.”.

13 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
14 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
15 section 9812 of such Code, as amended by subsection
16 (a)(1), is further amended by adding at the end the fol-
17 lowing new paragraph:

18 “(5) AVAILABILITY OF PLAN INFORMATION.—
19 The criteria for medical necessity determinations
20 made under the plan with respect to mental health
21 and substance-related disorder benefits shall be
22 made available by the plan administrator to any cur-
23 rent or potential participant, beneficiary, or con-
24 tracting provider upon request. The reason for any
25 denial under the plan of reimbursement or payment

1 for services with respect to mental health and sub-
2 stance-related disorder benefits in the case of any
3 participant or beneficiary shall, upon request, be
4 made available by the plan administrator to the par-
5 ticipant or beneficiary.”.

6 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
7 section (a) of section 9812 of such Code is further amend-
8 ed by adding at the end the following new paragraph:

9 “(6) MINIMUM SCOPE OF COVERAGE AND EQ-
10 UITY IN OUT-OF-NETWORK BENEFITS.—

11 “(A) MINIMUM SCOPE OF MENTAL
12 HEALTH AND SUBSTANCE-RELATED DISORDER
13 BENEFITS.—In the case of a group health plan
14 that provides any mental health or substance-
15 related disorder benefits, the plan shall include
16 benefits for any mental health condition or sub-
17 stance-related disorder for which benefits are
18 provided under the benefit plan option offered
19 under chapter 89 of title 5, United States Code,
20 with the highest average enrollment as of the
21 beginning of the most recent year beginning on
22 or before the beginning of the plan year in-
23 volved.

24 “(B) EQUITY IN COVERAGE OF OUT-OF-
25 NETWORK BENEFITS.—

1 “(i) IN GENERAL.—In the case of a
2 group health plan that provides both med-
3 ical and surgical benefits and mental
4 health or substance-related disorder bene-
5 fits, if medical and surgical benefits are
6 provided for substantially all items and
7 services in a category specified in clause
8 (ii) furnished outside any network of pro-
9 viders established or recognized under such
10 plan, the mental health and substance-re-
11 lated disorder benefits shall also be pro-
12 vided for items and services in such cat-
13 egory furnished outside any network of
14 providers established or recognized under
15 such plan in accordance with the require-
16 ments of this section.

17 “(ii) CATEGORIES OF ITEMS AND
18 SERVICES.—For purposes of clause (i),
19 there shall be the following three categories
20 of items and services for benefits, whether
21 medical and surgical benefits or mental
22 health and substance-related disorder bene-
23 fits, and all medical and surgical benefits
24 and all mental health and substance-re-

1 lated disorder benefits shall be classified
2 into one of the following categories:

3 “(I) EMERGENCY.—Items and
4 services, whether furnished on an in-
5 patient or outpatient basis, required
6 for the treatment of an emergency
7 medical condition (including an emer-
8 gency condition relating to mental
9 health or substance-related disorders).

10 “(II) INPATIENT.—Items and
11 services not described in subclause (I)
12 furnished on an inpatient basis.

13 “(III) OUTPATIENT.—Items and
14 services not described in subclause (I)
15 furnished on an outpatient basis.”.

16 (e) REVISION OF INCREASED COST EXEMPTION.—
17 Paragraph (2) of section 9812(c) of such Code is amended
18 to read as follows:

19 “(2) INCREASED COST EXEMPTION.—

20 “(A) IN GENERAL.—With respect to a
21 group health plan, if the application of this sec-
22 tion to such plan results in an increase for the
23 plan year involved of the actual total costs of
24 coverage with respect to medical and surgical
25 benefits and mental health and substance-re-

1 lated disorder benefits under the plan (as deter-
2 mined and certified under subparagraph (C)) by
3 an amount that exceeds the applicable percent-
4 age described in subparagraph (B) of the actual
5 total plan costs, the provisions of this section
6 shall not apply to such plan during the fol-
7 lowing plan year, and such exemption shall
8 apply to the plan for 1 plan year.

9 “(B) APPLICABLE PERCENTAGE.—With re-
10 spect to a plan, the applicable percentage de-
11 scribed in this paragraph shall be—

12 “(i) 2 percent in the case of the first
13 plan year to which this paragraph applies,
14 and

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

17 “(C) DETERMINATIONS BY ACTUARIES.—
18 Determinations as to increases in actual costs
19 under a plan for purposes of this subsection
20 shall be made by a qualified and licensed actu-
21 ary who is a member in good standing of the
22 American Academy of Actuaries. Such deter-
23 minations shall be certified by the actuary and
24 be made available to the general public.

1 “(D) 6-MONTH DETERMINATIONS.—If a
2 group health plan seeks an exemption under
3 this paragraph, determinations under subpara-
4 graph (A) shall be made after such plan has
5 complied with this section for the first 6
6 months of the plan year involved.”.

7 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
8 ERS.—Paragraph (1) of section 9812(c) of such Code is
9 amended to read as follows:

10 “(1) SMALL EMPLOYER EXEMPTION.—

11 “(A) IN GENERAL.—This section shall not
12 apply to any group health plan for any plan
13 year of a small employer.

14 “(B) SMALL EMPLOYER.—For purposes of
15 subparagraph (A), the term ‘small employer’
16 means, with respect to a calendar year and a
17 plan year, an employer who employed an aver-
18 age of at least 2 (or 1 in the case of an em-
19 ployer residing in a State that permits small
20 groups to include a single individual) but not
21 more than 50 employees on business days dur-
22 ing the preceding calendar year. For purposes
23 of the preceding sentence, all persons treated as
24 a single employer under subsection (b), (e),
25 (m), or (o) of section 414 shall be treated as 1

1 employer and rules similar to rules of subpara-
2 graphs (B) and (C) of section 4980D(d)(2)
3 shall apply.”.

4 (g) ELIMINATION OF SUNSET PROVISION.—Section
5 9812 of such Code is amended by striking subsection (f).

6 (h) CONFORMING AMENDMENTS TO HEADING.—

7 (1) IN GENERAL.—The heading of section 9812
8 of such Code is amended to read as follows:

9 **“SEC. 9812. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**
10 **RELATED DISORDER BENEFITS.”.**

11 (2) CLERICAL AMENDMENT.—The table of sec-
12 tions for subchapter B of chapter 100 of such Code
13 is amended by striking the item relating to section
14 9812 and inserting the following new item:

“Sec. 9812. Equity in mental health and substance-related disorder benefits.”.

15 (i) EFFECTIVE DATE.—

16 (1) IN GENERAL.—Except as otherwise pro-
17 vided in this subsection, the amendments made by
18 this section shall apply with respect to plan years be-
19 ginning on or after January 1, 2008.

20 (2) ELIMINATION OF SUNSET.—The amend-
21 ment made by subsection (g) shall apply to benefits
22 for services furnished after December 31, 2007.

23 (3) SPECIAL RULE FOR COLLECTIVE BAR-
24 GAINING AGREEMENTS.—In the case of a group
25 health plan maintained pursuant to one or more col-

1 lective bargaining agreements between employee rep-
2 representatives and one or more employers ratified be-
3 fore the date of the enactment of this Act, the
4 amendments made by this section (other than sub-
5 section (g)) shall not apply to plan years beginning
6 before the later of—

7 (A) the date on which the last of the col-
8 lective bargaining agreements relating to the
9 plan terminates (determined without regard to
10 any extension thereof agreed to after the date
11 of the enactment of this Act), or

12 (B) January 1, 2010.

13 For purposes of subparagraph (A), any plan amend-
14 ment made pursuant to a collective bargaining
15 agreement relating to the plan which amends the
16 plan solely to conform to any requirement imposed
17 under an amendment under this section shall not be
18 treated as a termination of such collective bar-
19 gaining agreement.

20 **SEC. 5. GOVERNMENT ACCOUNTABILITY OFFICE STUDIES**
21 **AND REPORTS.**

22 (a) **IMPLEMENTATION OF ACT.—**

23 (1) **STUDY.—**The Comptroller General of the
24 United States shall conduct a study that evaluates

1 the effect of the implementation of the amendments
2 made by this Act on—

3 (A) the cost of health insurance coverage;

4 (B) access to health insurance coverage
5 (including the availability of in-network pro-
6 viders);

7 (C) the quality of health care;

8 (D) Medicare, Medicaid, and State and
9 local mental health and substance abuse treat-
10 ment spending;

11 (E) the number of individuals with private
12 insurance who received publicly funded health
13 care for mental health and substance-related
14 disorders;

15 (F) spending on public services, such as
16 the criminal justice system, special education,
17 and income assistance programs;

18 (G) the use of medical management of
19 mental health and substance-related disorder
20 benefits and medical necessity determinations
21 by group health plans (and health insurance
22 issuers offering health insurance coverage in
23 connection with such plans) and timely access
24 by participants and beneficiaries to clinically-in-

1 dicated care for mental health and substance-
2 use disorders; and

3 (H) other matters as determined appro-
4 priate by the Comptroller General.

5 (2) REPORT.—Not later than 2 years after the
6 date of enactment of this Act, the Comptroller Gen-
7 eral shall prepare and submit to the appropriate
8 committees of the Congress a report containing the
9 results of the study conducted under paragraph (1).

10 (b) BIENNIAL REPORT ON OBSTACLES IN OBTAIN-
11 ING COVERAGE.—Every two years, the Comptroller Gen-
12 eral shall submit to each House of the Congress a report
13 on obstacles that individuals face in obtaining mental
14 health and substance-related disorder care under their
15 health plans.

16 (c) UNIFORM PATIENT PLACEMENT CRITERIA.—Not
17 later than 18 months after the date of the enactment of
18 this Act, the Comptroller General shall submit to each
19 House of the Congress a report on availability of uniform
20 patient placement criteria for mental health and sub-
21 stance-related disorders that could be used by group
22 health plans and health insurance issuers to guide deter-
23 minations of medical necessity and the extent to which
24 health plans utilize such criteria. If such criteria do not

- 1 exist, the report shall include recommendations on a proc-
- 2 ess for developing such criteria.