H. R. 4058

To provide for parity for mental health benefits under group health plans.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 11, 1996

Mrs. ROUKEMA (for herself, Mr. DeFAZIO, Mr. WISE, Mrs. JOHNSON of Connecticut, Mrs. MORELLA, Ms. NORTON, Ms. KAPTUR, Mr. McCOLLUM, Mr. KASICH, and Mr. HUTCHINSON) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Economic and Educational Opportunities, and Government Reform and Oversight, 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

A BILL

To provide for parity for mental health 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 SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Mental Health Parity

5 Act of 1996”.

SEC. 2. PLAN PROTECTIONS FOR INDIVIDUALS WITH A MENTAL ILLNESS.

(a) PERMISSIBLE COVERAGE LIMITS UNDER A GROUP HEALTH PLAN.—

(1) AGGREGATE LIFETIME LIMITS.—

(A) IN GENERAL.—With respect to a group health plan offered by a health insurance issuer, that applies an aggregate lifetime limit to plan payments for medical or surgical services covered under the plan, if such plan also provides a mental health benefit such plan shall—

(i) include plan payments made for mental health services under the plan in such aggregate lifetime limit; or

(ii) establish a separate aggregate lifetime limit applicable to plan payments for mental health services under which the dollar amount of such limit (with respect to mental health services) is equal to or greater than the dollar amount of the aggregate lifetime limit on plan payments for medical or surgical services.

(B) NO LIFETIME LIMIT.—With respect to a group health plan offered by a health insurance issuer, that does not apply an aggregate
lifetime limit to plan payments for medical or surgical services covered under the plan, such plan may not apply an aggregate lifetime limit to plan payments for mental health services covered under the plan.

(2) Annual limits.—

(A) In general.—With respect to a group health plan offered by a health insurance issuer, that applies an annual limit to plan payments for medical or surgical services covered under the plan, if such plan also provides a mental health benefit such plan shall—

(i) include plan payments made for mental health services under the plan in such annual limit; or

(ii) establish a separate annual limit applicable to plan payments for mental health services under which the dollar amount of such limit (with respect to mental health services) is equal to or greater than the dollar amount of the annual limit on plan payments for medical or surgical services.

(B) No annual limit.—With respect to a group health plan offered by a health insurance
issuer, that does not apply an annual limit to
plan payments for medical or surgical services
covered under the plan, such plan may not
apply an annual limit to plan payments for
mental health services covered under the plan.

(b) Rule of Construction.—

(1) In general.—Nothing in this section shall
be construed as prohibiting a group health plan of-
fered by a health insurance issuer, from—

(A) utilizing other forms of cost contain-
ment not prohibited under subsection (a); or

(B) applying requirements that make dis-
tinctions between acute care and chronic care.

(2) Nonapplicability.—This section shall not
apply to—

(A) substance abuse or chemical depend-
ency benefits; or

(B) health benefits or health plans paid for
under title XVIII or XIX of the Social Security
Act.

(3) State law.—Nothing in this section shall
be construed to preempt any State law that provides
for greater parity with respect to mental health ben-
efits than that required under this section.

(c) Small Employer Exemption.—
(1) IN GENERAL.—This section shall not apply to plans maintained by employers that employ less than 26 employees.

(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (e), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) 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.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

SEC. 3. DEFINITIONS.

For purposes of this Act:
(1) **Group Health Plan.**—

(A) **In General.**—The term “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(B) **Medical Care.**—The term “medical care” means amounts paid for—

(i) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i), and

(iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii).
(2) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(3) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (4)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974), and includes a plan sponsor described in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 in the case of a group health plan which is an employee welfare benefit plan (as defined in section 3(1) of such Act). Such term does not include a group health plan.
(4) HEALTH MAINTENANCE ORGANIZATION.—
The term “health maintenance organization”
means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act),
(B) an organization recognized under State law as a health maintenance organization, or
(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(5) STATE.—The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 4. SUNSET.
Section 2 shall cease to be effective on September 30, 2001.

SEC. 5. FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM.
For the Federal Employee Health Benefit Program, sections 2 and 3 will take effect on October 1, 1997.

SEC. 6. EXEMPTION.
Notwithstanding the provisions of this Act, if the provisions of this Act result in a 1 percent or greater increase
in the cost of a group health plan’s premiums, the pur-
chaser is exempt from the provisions of this Act.