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PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

OCTOBER 15, 2007.—Ordered to be printed

Mr. GEORGE MILLER of California, from the Committee on Education and Labor, submitted the following

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 1424]

[Including cost estimate of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (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, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Paul Wellstone Mental Health and Addiction Equity Act of 2007".

(b) TABLE OF CONTENTS.—The table of contents of 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. 5. Amendments to the Internal Revenue Code of 1986.
Sec. 5. Government Accountability Office studies and reports.

SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) EXTENSION OF PARITY TO TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended—

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

"(3) TREATMENT LIMITS.—

"(A) NO TREATMENT LIMIT.—If the plan or coverage does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose any treatment limit on mental health or substance-related disorder benefits that are classified in the same category of items or services.

"(B) TREATMENT LIMIT.—If the plan or coverage includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose such a treatment limit on mental health or substance-related disorder benefits for items and services within such category that is more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

"(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following five categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

"(i) INPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

"(ii) INPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

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

"(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

"(v) 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 condition relating to mental health and substance-related disorders).

"(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term 'treatment limit' means, with respect to a plan or coverage, 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 or coverage.

"(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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 limit or requirement with respect to such category of items and services.

"(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

"(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan or coverage does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified under paragraph (3)(C)), the plan or coverage may not impose such a beneficiary financial requirement on mental health or substance-related disorder benefits for items and services within such category.

"(B) BENEFICIARY FINANCIAL REQUIREMENT.—

"(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 (as specified in paragraph (3)(C)), the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related

disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

"(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage 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 predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

"(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as prohibiting the plan or coverage from waiving the application of any deductible for mental health benefits or substance-related disorder benefits or both.

"(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term 'beneficiary financial requirement' includes, with respect to a plan or coverage, 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 or coverage, but does not include the application of any aggregate lifetime limit or annual limit."; and

(2) in subsection (b)—

(A) by striking "construed—" and all that follows through "(1) as requiring" and inserting "construed as requiring";

(B) by striking "; or" and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking "mental health benefits" and inserting "mental health or substance-related disorder benefits" each place it appears; and

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

(A) by striking "MENTAL HEALTH BENEFITS" and inserting "MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS";

(B) by striking "benefits with respect to mental health services" and inserting "benefits with respect to services for mental health conditions or substance-related disorders"; and

(C) by striking ", but does not include benefits with respect to treatment of substance abuse or chemical dependency".

(c) AVAILABILITY OF PLAN INFORMATION ABOUT CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of such section, as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

"(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) 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 and substance-related disorder benefits in the case of any participant or beneficiary shall, upon request, be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.".

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

"(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

"(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition and substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

"(B) EQUITY IN COVERAGE OF OUT-OF-NETWORK BENEFITS.—

"(i) IN GENERAL.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

"(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

"(I) 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).

"(II) INPATIENT.—Items and services not described in subclause (I) furnished on an inpatient basis.

"(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.".

(e) CONSTRUCTION.—Subsection (a) of such section is further amended by adding at the end the following new paragraph:

"(7) CONSTRUCTION.—Nothing in this section shall be construed to limit a group health plan (or health insurance offered in connection with such a plan) from managing the provision of medical, surgical, mental health or substance-related disorder benefits through any of the following methods:

"(A) the application of utilization review;

"(B) the application of authorization or management practices;

"(C) the application of medical necessity and appropriateness criteria; or

"(D) other processes intended to ensure that beneficiaries receive appropriate care and medically necessary services for covered benefits;

to the extent such methods are recognized both by industry and by providers and are not prohibited under applicable State laws.".

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

"(2) INCREASED 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-related 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.

"(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

"(i) 2 percent in the case of the first plan year which begins after the effective date of the amendments made by section 101 of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 subsection shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

"(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with such a 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.—An election to modify coverage of mental health and substance-related disorder benefits as permitted under this paragraph shall be treated as a material modification in the terms of the plan as described

in section 102(a) and notice of which shall be provided a reasonable period in advance of the change.

"(F) NOTIFICATION OF APPROPRIATE AGENCY.—

"(i) IN GENERAL.—A group health plan that, based on upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall notify the Department of Labor of such election.

"(ii) REQUIREMENT.—A notification 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-related 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-related disorder benefits under the plan.

"(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Department of Labor shall make available, upon request to the appropriate committees of Congress 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 any type of employers submitting such notification; and

"(II) a summary of the data received under clause (ii).

"(G) NO IMPACT ON APPLICATION OF STATE LAW.—The fact that a plan or coverage is exempt from the provisions of this section under subparagraph (A) shall not affect the application of State law to such plan or coverage.".

(g) CHANGE IN EXCLUSION FOR SMALLEST EMPLOYERS.—Subsection (c)(1)(B) of such section is amended—

(1) by inserting "(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)" after "at least 2" the first place it appears; and

(2) by striking "and who employs at least 2 employees on the first day of the plan year".

(h) ELIMINATION OF SUNSET PROVISION.—Such section is amended by striking subsection (f).

(i) CLARIFICATION REGARDING PREEMPTION.—Such section is further amended by inserting after subsection (e) the following new subsection:

"(f) PREEMPTION, RELATION TO STATE LAWS.—

"(1) IN GENERAL.—This part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance issuers in connection with group health insurance coverage (including benefit mandates or regulation of group health plans of 50 or fewer employees) except to the extent that such provision prevents the application of a requirement of this part.

"(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

"(3) OTHER STATE LAWS.—Nothing in this section shall be construed to exempt or relieve any person from any laws of any State not solely related to health insurance issuers in connection with group health coverage insofar as they may now or hereafter relate to insurance, health plans, or health coverage.'".

(j) CONFORMING AMENDMENTS TO HEADING.—

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

"SEC. 712. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.".

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the item relating to section 712 and inserting the following new item:

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

(k) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2008.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—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 the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed under an amendment under this section shall not be treated as a termination of such collective bargaining agreement.

(l) DOL ANNUAL SAMPLE COMPLIANCE.—The Secretary of Labor shall annually sample and conduct random audits of group health plans (and health insurance coverage offered in connection with such plans) in order to determine their compliance with the amendments made by this Act and shall submit to the appropriate committees of Congress an annual report on such compliance with such amendments.

(m) ASSISTANCE TO PARTICIPANTS AND BENEFICIARIES.—The Secretary of Labor shall provide assistance to participants and beneficiaries of group health plans with any questions or problems with compliance with the requirements of this Act. The Secretary shall notify participants and beneficiaries when they can obtain assistance from State consumer and insurance agencies and the Secretary shall coordinate with State agencies to ensure that participants and beneficiaries are protected and afforded the rights provided under this Act.

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

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

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

"(3) TREATMENT LIMITS.—

"(A) NO TREATMENT LIMIT.—If the plan or coverage does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services (specified in subparagraph (C)), the plan or coverage 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.

"(B) TREATMENT LIMIT.—If the plan or coverage includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose such a treatment limit on mental health and substance-related disorder benefits for items and services within such category that are more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

"(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following four categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

"(i) INPATIENT, IN-NETWORK.—Items and services furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

"(ii) INPATIENT, OUT-OF-NETWORK.—Items and services furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

"(iii) OUTPATIENT, IN-NETWORK.—Items and services furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

"(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

"(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term 'treatment limit' means, with respect to a plan or coverage, 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 or coverage.

"(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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 limit or requirement with respect to such category of items and services.

"(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

"(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan or coverage does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified in paragraph (3)(C)), the plan or coverage may not impose such a beneficiary financial requirement on mental health and substance-related disorder benefits for items and services within such category.

"(B) BENEFICIARY FINANCIAL REQUIREMENT.—

"(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

"(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage may not impose such financial requirement on mental health and substance-related disorder benefits for items and services within such category in a way that is more costly to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

"(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term 'beneficiary financial requirement' includes, with respect to a plan or coverage, 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 or coverage, but does not include the application of any aggregate lifetime limit or annual limit."; and

(2) in subsection (b)—

(A) by striking "construed—" and all that follows through "(1) as requiring" and inserting "construed as requiring";

(B) by striking "; or" and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking "mental health benefits" and inserting "mental health and substance-related disorder benefits" each place it appears; and

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

(A) by striking "MENTAL HEALTH BENEFITS" and inserting "MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS";

(B) by striking "benefits with respect to mental health services" and inserting "benefits with respect to services for mental health conditions or substance-related disorders"; and

(C) by striking ", but does not include benefits with respect to treatment of substances abuse or chemical dependency".

(c) AVAILABILITY OF PLAN INFORMATION ABOUT CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of such section, as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

"(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related 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) 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 and substance-related disorder benefits in the case of any participant or beneficiary shall, upon request, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.".

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

"(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

"(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

"(B) EQUITY IN COVERAGE OF OUT-OF-NETWORK BENEFITS.—

"(i) IN GENERAL.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health and substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

"(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

"(I) 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 and substance-related disorders).

"(II) INPATIENT.—Items and services not described in subclause (I) furnished on an inpatient basis.

"(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.".

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

"(2) INCREASED 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-related 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.

"(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

"(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

"(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with such a 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.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the Employee Retirement Income Security Act of 1974 with respect to the a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.".

(f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOYERS.—Subsection (c)(1)(B) of such section is amended—

(1) by inserting "(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)" after "at least 2" the first place it appears; and

(2) by striking "and who employs at least 2 employees on the first day of the plan year".

(g) ELIMINATION OF SUNSET PROVISION.—Such section is amended by striking out subsection (f).

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

"(f) PREEMPTION, RELATION TO STATE LAWS.—

"(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies that are greater than the protections, benefits, methods of access to benefits, rights or remedies provided under this section.

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

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

"SEC. 2705.".

(j) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2008.

SEC. 4. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

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

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

"(3) TREATMENT LIMITS.—

"(A) NO TREATMENT LIMIT.—If the plan does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services (specified in subparagraph (C)), 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.

"(B) TREATMENT LIMIT.—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 and substance-related disorder benefits for items and services within such category that are more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

"(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following four categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

"(i) INPATIENT, IN-NETWORK.—Items and services furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

"(ii) INPATIENT, OUT-OF-NETWORK.—Items and services furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

"(iii) OUTPATIENT, IN-NETWORK.—Items and services furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

"(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

"(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term '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.

"(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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 limit or requirement with respect to such category of items and services.

"(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

"(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified in paragraph (3)(C)), the plan may not impose such a beneficiary financial requirement on mental health and substance-related disorder benefits for items and services within such category.

"(B) BENEFICIARY FINANCIAL REQUIREMENT.—

"(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

"(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan includes a beneficiary financial requirement not described in clause (i) 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 and substance-related disorder benefits for items and services within such category in a way that is more costly to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

"(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term '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, but does not include the application of any aggregate lifetime limit or annual limit."; and

(2) in subsection (b)—

(A) by striking "construed—" and all that follows through "(1) as requiring" and inserting "construed as requiring";

(B) by striking "; or" and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking "mental health benefits" and inserting "mental health and substance-related disorder benefits" each place it appears; and

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

(A) by striking "MENTAL HEALTH BENEFITS" in the heading and inserting "MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS";

(B) by striking "benefits with respect to mental health services" and inserting "benefits with respect to services for mental health conditions or substance-related disorders"; and

(C) by striking ", but does not include benefits with respect to treatment of substances abuse or chemical dependency".

(c) AVAILABILITY OF PLAN INFORMATION ABOUT CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of such section, as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

"(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits shall be made available by the plan administrator to any current or potential participant, beneficiary, or contracting 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 shall, upon request, be made available by the plan administrator to the participant or beneficiary.".

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

"(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

"(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

"(B) EQUITY IN COVERAGE OF OUT-OF-NETWORK BENEFITS.—

"(i) IN GENERAL.—In the case of a plan that provides both medical and surgical benefits and mental health and substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall 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 of this section.

"(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

"(I) 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 and substance-related disorders).

"(II) INPATIENT.—Items and services not described in subclause (I) furnished on an inpatient basis.

"(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.".

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

"(2) INCREASED COST EXEMPTION.—

"(A) IN GENERAL.—With respect to a group health plan, if the application of this section to such plan 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-related 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 during the following plan year, and such exemption shall apply to the plan for 1 plan year.

"(B) APPLICABLE PERCENTAGE.—With respect to a plan, the applicable percentage described in this paragraph shall be—

"(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 for purposes of this subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

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

(f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOYERS.—Subsection (c)(1) of such section is amended to read as follows:

"(1) SMALL EMPLOYER EXEMPTION.—

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

"(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term 'small employer' means, 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. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.".

(g) ELIMINATION OF SUNSET PROVISION.—Such section is amended by striking subsection (f).

(h) CONFORMING AMENDMENTS TO HEADING.—

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

"SEC. 9812.".

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 9812 and inserting the following new item:

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

(i) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2008.

SEC. 5. STUDIES AND REPORTS.

(a) IMPLEMENTATION OF ACT.—

(1) GAO STUDY.—The Comptroller General of the United States shall conduct a study that evaluates the effect of the implementation of the amendments made by this Act on—

(A) the cost of health insurance coverage;

(B) access to health insurance coverage (including the availability of in-network providers);

(C) the quality of health care;

(D) Medicare, Medicaid, and State and local mental health and substance abuse treatment spending;

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

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

(G) the use of medical management of mental health and substance-related disorder benefits and medical necessity determinations by group health plans (and health insurance issuers offering health insurance coverage in connection with such plans) and timely access by participants and beneficiaries to clinically-indicated care for mental health and substance-use disorders; and

(H) other matters as determined appropriate by the Comptroller General.

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

(b) GAO REPORT ON UNIFORM PATIENT PLACEMENT CRITERIA.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to the appropriate committees of each House of the Congress a report on availability of uniform patient placement criteria for mental health and substance-related disorders that could be used by group health plans and health insurance issuers to guide determinations of medical necessity and the extent to which health plans utilize such criteria. If such criteria do not exist, the report shall include recommendations on a process for developing such criteria.

(c) DOL BIANNUAL REPORT ON OBSTACLES IN OBTAINING COVERAGE.—Every two years, the Secretary of Labor, in consultation with the Secretaries of Health and Human Services and the Treasury, shall submit to the appropriate committees of

each House of the Congress a report on obstacles that individuals face in obtaining mental health and substance-related disorder care under their health plans.

I. 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.

Mental disorders are the leading cause of disability in the U.S. for individuals ages 15–44.[2] 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.

II. COMMITTEE ACTION INCLUDING LEGISLATIVE HISTORY AND VOTES IN COMMITTEE

102ND CONGRESS (1991–1992)

On May 12, 1992 during the 102nd Congress Senators Pete Domenici and John Danforth first introduced mental health parity legislation, Equitable Health Care for Severe Mental Illnesses Act of 1992, S. 2696. The legislation garnered 24 bipartisan co-sponsors and was referred to the Committee on Labor and Human Resources. S. 2696 prohibited discrimination in the healthcare system based on an individual's severe mental illness, and stated health care coverage. No action was taken on S. 2696.

The Senate Appropriations Committee included language in its Committee report[3] to accompany the FY1993 Labor-HHS appropriations bill that requested the National Advisory Mental Health Council prepare a report on the cost of mental health parity.

103RD CONGRESS (1993–1994)

Congress considered mental health parity during the debate on the Clinton Administration's health care reform proposal in the 103rd Congress. The Health Security Act (introduced as H.R. 3600 and S. 1757 respectively) included limited coverage of mental illness as part of its initial benefit package, however both bills provided for a phase-in of full parity by January 1, 2001. The Health

[1] P.L 104–204.

[2] 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).

[3] S. Rept. 102–397 at 96.

Security Act was deliberated in the House [4] and Senate [5] Committees of jurisdiction however no further action was taken on either bill.

104TH CONGRESS (1995–1996)

On January 31, 1995 Senators Domenici and Wellstone re-introduced the Equitable Health Care for Severe Mental Illnesses Act, S. 298 which sought to provide full mental health parity. The legislation had 7 co-sponsors and was similar to language approved by the Senate on April 18, 1996 as an amendment to S. 1028, the Health Insurance Reform Act. This amendment was later dropped in conference. A partial parity amendment offered by Senators Domenici and Wellstone was also rejected by the conferees as part of the Health Insurance Portability and Accountability Act (HIPAA). [6]

On August 2, 1996, Senators Pete Domenici and Paul Wellstone introduced S. 2031, the Mental Health Parity Act (MHPA). The bill had 16 bipartisan co-sponsors and was referred to the Committee on Labor and Human Resources. MHPA required parity for annual and lifetime dollar amounts; included an exemption for employers with 25 or fewer employees; and applied the parity provisions only to those group health plans that provided mental health coverage.

Representative Marge Roukema introduced the House version of the Mental Health Parity Act of 1996, H.R. 4058 on September 11, 1996. The MHPA garnered 22 bipartisan co-sponsors and was referred to the Committee on Commerce, Subcommittee on Health and Environment; the Committee on Economic and Educational Opportunities, Subcommittee on Employer-Employee Relations; and the Committee on Government Reform and Oversight, Subcommittee on Civil Service.

MHPA was offered as an amendment to the FY 1997 VA-HUD appropriations bill, H.R. 3666. On September 5, 1996, the Senate approved the Domenici-Wellstone amendment, as amended [7] by an 82–15 vote. On September 11, 1996, the House voted 392–17 to adopt a motion to instruct conferees on H.R. 3666 and among other things, to agree to the Senate mental health parity provisions. The Domenici-Wellstone amendment was agreed to in conference and MHPA became Title VII of the FY1997 VA-HUD appropriations bill, which was signed into law on September 26, 1996. [8]

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[4] H.R. 3600 was referred to the: House Ways and Means Committee, Subcommittee on Select Revenue Measures, Subcommittee on Health, Subcommittee on Social Security; Armed Services Committee, Subcommittee on Military Forces and Personnel; Education and Labor Committee, Subcommittee on Labor Standards, Occupational Health and Safety, Subcommittee on Postsecondary Education and Training, Subcommittee on Elementary, Secondary, and Vocational Education, Subcommittee on Labor-Management Relations, Subcommittee on Human Resources, Subcommittee on Select Education and Civil Rights; Government Operations Committee, Subcommittee on Information, Justice, Transportation, and Agriculture, Subcommittee on Legislation and National Security, Subcommittee on Human Resources and Intergovernmental Relations; Energy and Commerce Committee, Subcommittee on Health and Environment, Subcommittee on Commerce, Consumer Protection, and Competitiveness; Natural Resources Committee, Subcommittee on Native American Affairs; Judiciary Committee, Subcommittee on Economic and Commercial Law; Post Office and Civil Service Committee; Rules Committee; Veterans' Affairs Committee, Subcommittee on Hospitals and Health Care.

[5] On April 26, 1994, the Senate Finance Committee held a hearing on S. 1757.

[6] P.L. 104–191.

[7] By voice vote, the Senate approved a second degree amendment offered by Senator Gramm which exempted health plans from the MHPA parity requirement if the cost of compliance exceeded the original cost of coverage by 1 percent.

[8] P.L 104–204. See also, Ramya Sundararaman, "The Mental Health Parity Act: A Legislative History," CRS Report for Congress, May 18, 2007 at 5.

105TH CONGRESS (1997–1998)

During Congress' debate on the Balanced Budget Act of 1997 during the 105th Congress, Senators Domenici and Wellstone successfully attached an amendment to the State Children's Health Insurance Plan (SCHIP) which required plans offering mental health benefits to provide full-parity coverage. Although the language was later deleted in conference, the conferees did accept language that required all SCHIP plans and Medicaid managed care plans to meet the requirements of the MHPA. The MHPA provisions were also added to the Internal Revenue Code (IRC) through the Taxpayer Relief Act of 1997. [9]

On March 26, 1998, Representative Marge Roukema introduced the Mental Health and Substance Abuse Parity Amendments of 1998, H.R. 3568. The bill had 26 Democratic and Republican co-sponsors and was referred to the: Commerce Committee, Subcommittee on Health and the Environment; Education and the Workforce Committee, Subcommittee on Employer-Employee Relations; Ways and Means Committee, Subcommittee on Health. No further action was taken on H.R. 3568.

106TH CONGRESS (1999–2000)

On April 14, 1999, the Mental Health Equitable Treatment Act, S. 796 was introduced by Senators Pete Domenici and Paul Wellstone. S. 796 had 28 Democratic and Republican co-sponsors and was referred to the Committee on Health, Education, Labor, and Pensions.

On May 18, 2000, the Senate HELP committee held a hearing entitled Examining Mental Health Parity Issues, including S. 796, To Provide for Full Parity with Respect to Health Insurance Coverage for Certain Severe Biologically-based Mental Illnesses and to Prohibit Limits on the Number of Mental Illness-Related Hospital Days and Outpatient Visits that are Covered for All Mental Illnesses. The hearing consisted of three panels. The witnesses for the first panel included: Senator Pete V. Domenici and Senator Paul D. Wellstone. The second panel included: Kathryn G. Allen, Associate Director of Health Financing and Public Health Issues of the U.S. General Accounting Office and Dr. Steven E. Hyman, Director of the National Institute of Mental Health of the National Institute of Health. The third panel witnesses included: Ken Libertoff, Director of the Vermont Association for Mental Health; Dr. Kenneth Duckworth, Deputy Commissioner of the Massachusetts Department of Mental Health; Tara Wooldridge, Manager of the Employee Assistance Program of Delta Airlines; and Dean Rosen, senior Vice President of Policy and General Counsel of the Health Insurance Association of America.

Representative Marge Roukema re-introduced the Mental Health and Substance Abuse Parity Amendments of 1999, H.R. 1515 on April 21, 1999. The bill which had 114 Democratic and Republican co-sponsors was referred to the: Commerce Committee, Subcommittee on Health and the Environment; Education and the Workforce Committee, Subcommittee on Employer-Employee Rela-

[9] P.L. 105–34, Section 1531(a)(4), codified at 26 U.S.C. 9812.

tions; Ways and Means Committee, Subcommittee on Health. No further action was taken on H.R. 1515.

107TH CONGRESS (2001–2002)

On March 15, 2001, the Mental Health Equitable Treatment Act of 2001 was introduced by Senators Pete Domenici and Paul Wellstone. The bill garnered 66 Democratic and Republican cosponsors and was referred to the HELP Committee.

Senate consideration of mental health parity legislation

On July 11, 2001 the Senate HELP Committee held a hearing entitled Achieving Parity for Mental Health Treatment. The witnesses included: Senator Paul Wellstone; Senator Pete Domenici; Edward Flynn, Associate Director for Retirement and Insurance of the Office of Personnel Management; Lisa Cohen; Dr. Henry Harbin, Chairman of the Board and Chief Executive Officer of Magellan Health Services; and Dr. Darrel A. Regier, Executive Director of the American Psychiatric Institute for Research and Education.

On August 1, 2001, the Committee unanimously approved a substitute version of S. 543. On October 30, 2001, Senators Domenici and Wellstone offered S. 543, as reported, as an Senate Amendment 2020 to FY 2002 Labor-HHS appropriations bill, H.R. 3061, which the Senate approved by voice vote. The House version of H.R. 3061 did not include any parity language and on December 18, 2001, the House conferees rejected Representative Kennedy's motion to accept the Domenici-Wellstone mental health parity amendment. The conference did approve Representative Duke Cunningham's motion to include language in the bill reauthorizing the MHPA through December 31, 2002.

Consideration of mental health parity legislation in the House of Representatives

On January 3, 2002, Representative Marge Roukema re-introduced the Mental Health and Substance Abuse Parity Amendments, H.R. 162. The bill was cosponsored by 202 Democratic and Republican members. H.R. 162 was referred to the Energy and Commerce Committee, Subcommittee on Health; the Education and the Workforce Committee, Subcommittee on Employer-Employee Relations; and the Ways and Means Committee, Subcommittee on Health.

Committee consideration of mental health parity

On March 13, 2002 the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce held a hearing entitled, Assessing Mental Health Parity: Implications for Patients and Employers. The witnesses before this hearing included: Representative Marge Roukema; Representative Patrick Kennedy; Representative Lynn Rivers; Kay Nystul, Behavioral Health Nurse and Case Management Coordinator of Wausau Benefits; Lee Dixon, Group Director of Health Policy Tracking Service of the National Conference of State Legislatures; Dr. Henry Harbin, Chairman of the Board of Magellan Health Services Inc.; and Jane Greenman, Vice President of Human Resources and Communications and Deputy General Counsel of Honeywell International.

On July 23, 2002, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled Insurance Coverage of Mental Health Benefits. The witnesses were Charles M. Cutler, Chief Medical Officer of the American Association of Health Plans; James T. Hackett, Chairman, President, and Chief Executive Officer of Ocean Energy Inc.; Kay Nystul, Psychiatric Registered Nurse and Certified Case Manager of Wausau Benefits Inc.; Darrel A. Regier, Director of the Office of Research or the American Psychiatric Association; and Neil E. Trautwein, Director of Employment Policy of the National Association of Manufacturers.

Despite holding hearings, no further action was taken on the mental health parity legislation introduced in the House of Representatives. However, in two separate legislative actions, Congress reauthorized MHPA through December 31, 2003. [10]

108TH CONGRESS (2003–2004)

On January 7, 2003 Senator Thomas Daschle introduced the Health Care Coverage Expansion and Quality Improvement Act of 2003, S. 10. S. 10 required health plans treat mental illness in a nondiscriminatory and equitable manner by covering essential mental health treatment. The bill had 22 co-sponsors and was referred to the Senate Finance Committee. No further action was taken on the bill.

On February 27, 2003, Representatives Patrick Kennedy and Jim Ramstad introduced the Senator Paul Wellstone Mental Health and Equitable Treatment Act of 2003, H.R. 953. The bill garnered 248 bipartisan co-sponsors and was referred to the Energy and Commerce Committee, Subcommittee on Health; the Education and the Workforce Committee, Subcommittee on Employer-Employee Relations. There was no further consideration of the bill in the house.

Also on February 27, 2003, Senators Pete Domenici and Edward Kennedy introduced the Senate version of the Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, S. 486. The Act had 69 bipartisan co-sponsors and was referred to the Committee on Health, Education, Labor, and Pensions. No further action was taken on this legislation.

On November 4, 2003 the Senate HELP Committee, Subcommittee on Substance Abuse and Mental Health held a hearing on "Recommendations to Improve Mental Health Care in America: Report from the President's new Freedom Commission on Mental Health." The witnesses included: Stephen W. Mayberg, Commissioner of The President's New Freedom Commission on Mental Health; Charles G. Curie, Administrator of the Substance Abuse and Mental Services Administration on behalf of the Campaign for Mental Health Reform; Dr. Paul S. Appelbaum, Professor of Psychiatry at the University of Massachusetts Medical School; Michael M. Faenza, President and Chief Executive Officer, national Mental Health Association on behalf of the Campaign for Mental Health

[10] Section 610 of the Job Creation and Worker Assistance Act of 2002 (H.R. 3090, P.L. 107–147) amended MHPA provisions in the IRC, and the Mental Health Parity Reauthorization Act of 2002 (H.R. 5716, P.L. 107–313) reauthorized the MHPA provisions in ERISA and the PHSA. H.R. 5716 was introduced by Representative John Boehner on November 13, 2002 and approved without objection by the House on November 15, 2002. On the same day, the Senate received and passed the bill by unanimous consent.

Reform; Carlos Brandenberg, Administrator of Nevada Division of Mental Health and Developmental Services; and Ann Buchanan.

On November 17, 2003, Senator Judd Gregg introduced the Mental Health Parity Reauthorization Act of 2003, S. 1875, with Senator Edward Kennedy. However, on November 21, 2003, a new version of the Mental Health Parity Reauthorization Act of 2003, S. 1929, was introduced by Senators Gregg and Kennedy. S. 1929 was approved in the Senate by unanimous consent on the same day. On December 8, 2003 it was passed by the House by unanimous consent and became Public Law 108–197 on December 19, 2003.

109TH CONGRESS (2005–2006)

On March 17, 2005, Representatives Patrick Kennedy and Jim Ramstad reintroduced the Paul Wellstone Mental Health Equitable Treatment Act, H.R. 1402. The bill had 231 co-sponsors and was referred to the Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations; and the Committee on Energy and Commerce, Subcommittee on Health. On September 28, 2006, Representative Patrick Kennedy filed a discharge petition to request the bill be released from Committee and brought to the floor for consideration. The discharge petition gathered only 175 of the 218 member signature needed for discharge and subsequently failed.

No further action was taken in either the House of Representatives or the Senate however Congress extended MHPA through the end of 2007. [11]

110TH CONGRESS (2007)

The Mental Health Parity Act of 2007, S. 558 was first introduced by Senators Pete V. Domenici and Edward Kennedy on February 12, 2007 with 53 bipartisan co-sponsors. It was referred to the Senate HELP Committee and subsequently to the Subcommittee on Health.

In the House of Representatives, the Paul Wellstone Mental Health and Addiction Equity Act of 2007 was first introduced by Representatives Patrick Kennedy and Jim Ramstad as H.R. 1367 on March 7, 2007 with 255 co-sponsors. Two days later, on March 9, 2007 a modified version of the bill was introduced and has garnered 268 Democratic and Republican co-sponsors. H.R. 1424 was referred to the Committee on Energy and Commerce, Subcommittee on Health; the Committee on Education and Labor, Subcommittee on Health, Employment, Labor, and Pensions; and the Committee on Ways and Means, Subcommittee on Health.

Senate action on mental health parity legislation

On February 14, 2007, the HELP Committee held an executive session to markup S. 558. During the markup Senator Harkin offered an amendment by Senator Dodd, which included a technical

[11] P.L. 109–151. In the first session of the 109th Congress, the Employee Retirement Preservation Act, H.R. 4579 (P.L. 109–151), extended the provisions requiring mental health parity in ERISA, the PHS Act, and the IRC through 2006. H.R. 4579 passed the House by voice vote on December 17, 2005, and passed the Senate by unanimous consent on December 22, 2005. In the second session, Section 115 of the Tax Relief and Health Care Act of 2006, H.R. 6111 (P.L. 109–432) extended MHPA provisions in all three statutes through 2007.

change to clarify provisions relating to a GAO study. This amendment required GAO to examine and report on the impact of out-of-network coverage for mental health benefits. The amendment was adopted by unanimous consent and the bill was favorably reported to the full Senate by a vote of 18–3. On March 27, 2007, the Committee met again and reported an amended version of S. 558 with an amendment in the nature of a substitute offered by Chairman Kennedy.

Hearings on mental health parity in the House of Representatives

Ways and Means Committee, Health Subcommittee

On March 27, 2007, the Subcommittee on Health of the Ways and Means Committee held a three panel hearing entitled Mental Health and Substance Abuse Parity. Witnesses testifying on panel one included: Representatives Patrick Kennedy, and Jim Ramstad; Witnesses on panel two included: David L. Shern, Ph.D., President and CEO, Mental Health America, Kathryne L. Westin, M.A., L.P., Eating Disorders Coalition for Research, Policy and Action, and Michael Quirk, Ph.D., Director, Behavioral Health Service, Group Health Cooperative. Panel three included: Eric Goplerud, Ph.D., Director, Ensuring Solutions to Alcohol Problems, George Washington University; Ronald W. Manderscheid, Ph.D., Director of Mental Health and Substance Use Programs Constella Group LLC; and Henry T. Harbin, M.D.

Energy and Commerce Committee, Subcommittee on Health

On June 15, 2007, the Subcommittee on Health of the Committee on Energy and Commerce held a hearing entitled H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. The witnesses included: Representative Patrick Kennedy; Representative Jim Ramstad; James Purcell, President and Chief Executive Officer of Blue Cross & Blue Shield of Rhode Island; Marley Prunty-Lara; Howard Goldman, Professor of Psychiatry of the University of Maryland; Edwina Rogers, Vice President of Health Policy for the ERISA Industry Committee; and James Klein, President of the American Benefits Council.

Education and Labor Committee, HELP Subcommittee

On July 10, 2007, the Subcommittee on Health, Employment, Labor, and Pensions of the Committee on Education and Labor held a two-panel hearing entitled the Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424). The first panel included: Representative Patrick Kennedy and Representative Jim Ramstad. The second panel included: Rosalynn Carter, former First Lady and chairwoman of the Carter Center's Mental Health Task Force; David Wellstone, son of the late Senator Paul Wellstone and co-founder of Wellstone Action; Sean Dilweg, Insurance Commissioner for the State of Wisconsin; Amy Smith, Vice President of Mental Health Association of Colorado; Steve Melek, actuary for Milliman Inc.; Neil Trautwein, Employee Benefits Policy Counsel for the National Retail Federation; and Jon Breyfogle, executive principal for the Groom Law Group.

Education and Labor Committee full committee mark-up of the Paul Wellstone Mental Health and Addiction Equity Act of 2007

On July 18, 2007, the Committee on Education and Labor met to markup H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. The Committee adopted by voice vote an amendment in the nature of a substitute offered by Chairman Miller and reported the bill favorably as amended by a vote of 33–9 to the House of Representatives.

The Miller amendment incorporates the provisions of H.R. 1424 with the following modifications:

- Adds emergency care to the list of categories of items and services that are subject to the treatment limit parity requirements (other categories are inpatient in-network, inpatient out-of-network, outpatient in-network, and outpatient out-of-network).
- Makes clear that the requirement that group health plans make available to patients and providers their criteria for medical necessity determinations and reasons for any denial under the plan be provided in accordance with Department of Labor regulations.
- Adds a provision that group health plans may utilize industry and provider recognized benefit management practices for medical, surgical, mental health and substance related disorder benefits.
- Conforms preemption of state laws to existing HIPAA standards with specific protection of state laws relating to health insurance issuers including state laws providing for external review, requiring minimum benefits, covering employers with fewer than 50 employees, or solely related to health insurance issuers.
- Makes clear that collectively bargained plans become subject to the Act upon the expiration of an existing collective bargaining agreement.
- Requires the Department of Labor to annually sample and conduct random audits of group health plans to ensure compliance with the Act.
- Requires the Department of Labor to assist individuals with any questions or problems under the Act and to coordinate with state consumer protection agencies.

The Kline amendment in the nature of a substitute was defeated by a vote of 16–27. The amendment incorporated an amended version of S. 558, the Senate Mental Health Parity Act of 2007.

The Kline amendment differed from H.R. 1424 in at least two key areas. First, the Kline amendment would expressly permit every employer or health insurance issuer to establish its own definition of "mental health benefits." In contrast, H.R. 1424 seeks to provide private sector employees the same mental health coverage provided to federal employees by requiring group health plans to utilize the definition of mental health benefits under by the federal employee health plan with the largest average enrollment of federal employees.

The Committee supported the need for a federal standard for covered mental health benefits because of the long history of employer and insurer denial of coverage for mental health illnesses. As described elsewhere in this report, employers and insurers, historically and currently, have not provided comparable coverage of mental illnesses as they have of physical illnesses. For example, employers and insurers generally do not list covered and non-covered

physical illnesses, whereas such delineation of mental illnesses is commonplace.

The Kline Substitute would have permitted employers to create millions of definitions of mental health benefits undermining the need for uniformity that employers claim to seek. Employers would be free to eviscerate the intent of the Act simply by defining mental health benefits to exclude benefits the employer or insurer does not want to cover. This would allow insurance companies and group health plans to codify discrimination by diagnosis allowing plans to use arbitrary, non-scientific criteria in determining what mental illnesses and addiction disorders to cover.

The minority may argue that creation of a federal definition of mental health benefits exceeds "technical parity" since federal law does not define medical or surgical benefits. But, there is no data or allegations that employers or insurers narrowly define medical benefits, whereas there is ample data that employers and insurers have used narrow mental health definitions to evade coverage. Without a definition of covered mental health benefits, mental health parity legislation would continue to include loopholes that make parity an illusory promise.

The minority also expresses concern that defining mental health benefits would create a "new mandate" and could increase employer costs and reduce employer health benefit coverage. Again, the minority is ignoring the history and evidence on this matter. Both federal and state law traditionally and repeatedly set minimum standards for the provision of health care benefits when public policy concerns have warranted such. Experience has demonstrated that such minimum standards do not lead to reduced coverage or increased costs. Specifically with respect to mental health parity legislation, neither the federal employee, state nor private sector experience bears out the minority's fears. As noted below, the Congressional Budget Office (CBO), U.S. Government Accountability Office (GAO), and numerous other actuarial analyses have documented that expanded mental health coverage does not significantly increase costs or reduce coverage.

Second, the Kline Substitute differed from H.R. 1424 in its preemption of state health care laws. The Majority and minority face fundamental differences on the issue of preemption. Historically, states have had the primary responsibility for protecting the public health of their citizens. States have regulated the provision of insurance, including health insurance, for hundreds of years. In fact, even into current times, the insurance community has preferred state regulation over federal regulation of insurance practices.

Congress' active involvement with national health care primarily began with the enactment of Medicare and Medicaid in 1965 and Congress has struggled with the need for additional national reforms ever since. Since 1996, a key principle for Congress has been to incrementally reform private health coverage by establishing a federal floor of protections for workers and their families. Through a federal standard that is a floor, not a ceiling, Congress has recognized that state policymakers may determine that to protect patients in state-regulated plans, a stronger set of standards are necessary than those provided in federal law. In fact, many states now require insurance companies to cover mental health services. This

bill recognizes and encourages states to enact stronger consumer protections.

In addition to benefit requirements, many states have set standards to improve the quality of coverage to ensure that health insurance actually works for people who need it, while establishing rules to combat abusive practices by some in the health insurance industry. States have used a myriad of strategies to accomplish that, including patient protections and standards for medical management. Nothing in this bill is intended to in any way to affect those (or future) state efforts.

Understandably, large employers who operate in multiple states prefer a single unified system—with one set of rules with which they must comply and treat their employees. But, large employers who once accepted the need for some federal minimum health care standards, now generally want only minimal rules at both the federal and state level. The employer community has used the Employee Retirement Income Security Act (ERISA)[12] ERISA as a shield against both federal and state health care protections. Only the most sophisticated legal and health care experts know that ERISA contains few health care standards. ERISA is primarily a pension law that establishes detailed standards for information, coverage, and funding of pension promises. While ERISA applies to all employer provided employee benefits, it does not generally contain minimum health care standards. Enacted in 1974, Congress expected that it would shortly adopt comprehensive federal standards. Congress has attempted to enact national health care standards on several occasions, but without success.

As a result, the United States has not created a national system for providing health care to all citizens. Rather, it has a patchwork of federal and state and local laws providing a wide variety of health care requirements and protections for employers, insurers, and citizens. The large employers argue that only the federal government should set standards and preferably minimal ones. Congress' choice is either to adopt comprehensive federal standards, free the states to enact comprehensive state standards or to continue dual federal and state regulation.

Further complicating the issue is the illogical treatment of "insured" versus "self-insured" plans. Under current judicial interpretation of ERISA, if an employer establishes a health plan and the employer is the insurer of the plan, then the states are generally preempted from regulating the health plan. However, if the employer contracts with a state licensed insurance company or other state sanctioned health care entity, then the state may directly regulate the behavior of the insurer or other entity, and indirectly affect the actions of the health plan. Despite the illogic of this regulatory scheme, in the absence of broader Congressional direction on comprehensive health care reform, H.R. 1424 continues this existing system of split federal versus state oversight of health plans and benefits.

However, solely with respect to mental health parity laws, H.R. 1424 seeks to provide some improvement in the longstanding morass created by ERISA's preemption of state laws. Thousands of court cases and dozens of law review articles have argued over the

[12] P.L. 93–406.

correct intent and interpretation of ERISA preemption of state laws. On the whole, ERISA preemption has served to take away legal protections for workers and consumers. Although Congress' original intent had been strong federal standards over state standards, judicial interpretation of ERISA has created weak federal standards and minimal state protection. Congress' long debate over what was known as the Patient's Bill of Rights[13] amply documented how ERISA preemption has harmed consumers and undermined long term health care reform efforts.

H.R. 1424 rejects the continuation of this unfair preemption scheme. The bill adopts the model created by the Health Insurance Portability and Accountability Act of 1996.[14] The bill generally would not preempt state laws that do not "prevent the application" of federal mental health parity standards. The bill also specifically enumerates types of laws that Congress does not intend to preempt. Those laws include state laws establishing, implementing or continuing consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance issuers. The bill also specifically does not intend to preempt state laws containing benefit mandates, regulation of small employer group health plans or state laws solely related to health insurance issuers. Further, this bill would not relieve a company—licensed or registered under state law to perform utilization review—from its licensing or other applicable standards and obligations under state law. Unlike ERISA, HIPAA's preemption provisions have not been subject to excessive litigation and have provided certainty to consumers, employers and states.

Both the House and Senate passed versions of the Genetic Information Nondiscrimination Act, H.R. 493 used the HIPAA model to coordinate between federal and state regulatory policies.

In contrast, the Kline Substitute provides exceptions to its general preemption that are ambiguous and likely would invite innumerable ERISA litigation challenges.[15] The first exception seeks to clarify that portions of state law not preempted will continue to apply and that individual and small group coverage standards are not preempted. Yet, the language in Kline Substitute does not clearly ensure protection of existing individual and small group insurance market state laws. If the Kline Substitute were to become law, then states with one mental health coverage standard that applies to policies sold in the large group, small group and individual health insurance markets most likely can expect preemption challenges to their individual and small group mental health laws.[16]

In addition, the Kline Substitute would not preempt state coverage laws for "specific items, benefits, or services." These terms are not defined and thus the ambiguity of this language makes it unclear as to what type of state law would qualify as requiring "specific items, benefits, or services." Furthermore, it is unclear as to whether a qualified law coupled with "parity requirements" (e.g.

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[13] The Patient's Bill of Rights Act of 2005, H.R. 2259 was introduced in the House on May 11, 2005 by Representative John Dingell. Senator Edward Kennedy introduced the Senate version of the bill, S. 1012 on May 12, 2005.

[14] P.L. 104–191.

[15] See, Mila Koffman, Letter to Speaker Nancy Pelosi (June 15, 2007). Mila Koffman is a nationally recognized expert on insurance regulation, unauthorized insurance and ERISA. She previously served as a federal regulator at the U.S. Department of Labor and as a special assistant to the Senior Health Care Advisor to President Bill Clinton.

[16] Id.

requiring alcohol abuse treatment) would be eligible under this exception. Again, clarification would have to be determined through litigation.[17]

An example of how the Senate proposal would create ambiguity can be demonstrated by California's mental health parity law. California has a standard mental health parity law which applies generally to health insurance coverage. Since California does not apply a specific law to the individual and small group markets, there is no guarantee that courts will uphold the law under an ERISA preemption challenge. In addition, Connecticut's mental health coverage law has elements of "parity" and therefore may have to be litigated to determine which, if any, requirements would survive preemption.[18]

In addition to preempting stronger state parity laws and allowing insurance companies and group health plans to discriminate against an array of mental and substance abuse illnesses, the Kline Substitute does not provide any legal remedies for patients. Many Members of the Committee have long supported meaningful remedies for violations of the law and H.R. 1424 seeks to make clear that Congress never intended to preempt state insurance laws that provide legal protections to individuals covered by state regulated insurance products.

III. Summary of the Bill

The Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424 amends the ERISA and the Public Health Service Act (PHSA)[19] to prohibit employer group health plans offering mental health benefits from imposing mental health treatment limitations or financial requirements at a less comparable rate to the requirements and limitations they impose on medical or surgical benefits. The bill does not mandate group health plans to provide any mental health coverage; however, if the group health plan does offer mental health coverage then there must be equity between mental health coverage and all comparable medical and surgical benefits that the plan covers. H.R. 1424 makes clear that equity in financial requirements, treatment limitations, and out of network coverage is essential to a strong federal mental health parity law. Furthermore, the plan must cover the same range of mental illnesses and addiction disorders covered by the Federal Employee Health Plan that most federal employees and Members of Congress use.[20] As of July 18, 2007, H.R. 1424 had 268 co-sponsors, 230 Democrats and 38 Republicans.

IV. Statement and Committee Views

The Committee on Education and Labor of the 110th Congress is committed to improving access to health care, including treatment for mental health and substance disorders. The Paul Wellstone Mental Health and Addiction Equity Act addresses the inequities that those with mental illness experience in their health care coverage. The bill would prohibit group health plans from im-

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[17] Id.
[18] Id.
[19] 42 U.S.C. §6A.
[20] Summary of H.R. 1424, available at: *http://www.thomas.gov/cgi-bin/bdquery/z?d110:h.r.01424.*

posing financial requirements or treatment limitations on the coverage of mental health conditions and substance abuse that are more limited than those available for medical and surgical benefits. The Act is a cost-effective way of promoting increased access to mental health care.

To echo the words of former First Lady Rosalyn Carter, who testified before the Education and Labor Committee's Health, Employment, Labor, Pensions (HELP) Subcommittee:

> it is unconscionable in our country and morally unacceptable to treat 20 percent of our population (1 in every 5 people in our country will experience a mental illness this year) as though they were not worthy of care . . . [t]hen we pay the price for this folly in homelessness, lives lost, families torn apart, loss of productivity.[21]

Mental Illness: An Overview

An estimated 40 million American adults suffer from some type of mental illness each year, while 5.5 million or 6 percent suffer from a severe mental illness such as schizophrenia or major depression.[22] Approximately 1 in 17 Americans suffer from a serious mental illness; about 12 million children suffer from mental disorders such as autism, depression and hyperactivity;[23] and every year, about 54 million Americans suffer from clearly diagnosable mental or substance abuse disorders.[24] Overall, approximately 26.2 percent of Americans are afflicted with mental illness or substance abuse disorders;[25] while 14.8 million Americans suffer from depression; and 2.4 million suffer from schizophrenic disorders.

Mental health is essential to leading a healthy life and to the development and realization of a person's full potential.[26] For those who suffer from mental illness, "mental disorders are treatable . . . there is generally not just one but a range of treatments of proven efficacy."[27] Despite proven treatments, due to the social stigma and lack of understanding about the disease, mental illness often goes untreated. As a result, mental illness and substance-abuse disorders are leading causes of disability and premature mortality.[28] As scientific knowledge about mental health has grown and analyses have proven a nominal economic impact on the consumer, the employer, and the insurance company with respect to mental health, coverage for mental illness continues to expand. Nevertheless, stigma still remains; the result is that many people in need of mental services are prevented from receiving proper care.

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[21] The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) (written testimony of Rosalyn Carter) [hereinafter Carter Testimony].

[22] The Government Accounting Office (GAO). "Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited," (May 2000) at 7.

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

[24] National Mental Health Association, "Mental Illness in the Family," 2005.

[25] National Institutes of Mental Health, "The Numbers Count: Mental Disorders in America," 2006.

[26] Mental Health and Substance Abuse Parity, hearing before the House Committee on Ways and Means, Subcommittee on Health, 110th Cong., 1st Sess. (2007) at 1 (written testimony of David L. Shern) [hereinafter Shern Testimony].

[27] U.S. Dep't of Health & Human Svrs., Mental Health: A Report of the Surgeon General 46, 179 (1999) hereinafter SGRMH].

[28] Id.

The term mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.[29]

Social stigma about mental illness dates as far back as the 17th Century.[30] The stigmatization of mental illness is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. It is this stigma that leads people to avoid living, socializing or working with, renting to, or employing people with mental disorders. Stigma also reduces an individual's access to resources and opportunities such as jobs and housing as well as leading to low self-esteem, isolation, and hopelessness.[31]

The public attitude toward mental illness has been surveyed nationally since the 1950s.[32] In the 1950s, many people displayed an unscientific understanding of mental illness and had difficulty distinguishing mental illness from ordinary unhappiness. It was this misunderstanding of mental illness, along with the fear of unpredictable and violent behavior that perpetuated the social stigma behind it.[33]

Although Americans had achieved a better scientific understanding of mental illness by 1996, social stigma had not diffused. As the public's acceptance of classifying anxiety and depression as mental disorders has grown so has their perception that mental illness frequently incorporates violent behavior.[34] In 1996, 31 percent of the people surveyed mentioned violence in their descriptions of mental illness, in comparison with 13 percent in the 1950s.[35]

In the late 1990s, people with diagnosable mental disorders did not seek treatment due to the social stigma surrounding mental illness.[36] Furthermore, the public was reluctant to pay for less severe mental health conditions due in large part to stigma but also due to their realization that higher taxes and premiums would be necessary to offset these costs.[37] As former First Lady Carter testified, "if insurance covered mental illnesses, it would be right to have them. This may be why the stigma has remained so pervasive. Because these illnesses are treated differently from other health conditions."[38]

Mental health coverage today

Health insurance plans have long imposed barriers that limit access to needed behavioral health care with far-reaching and often tragic results.[39] No comparable barriers limit access to needed care

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[29] *Id.*

[30] Patrick Kennedy. "Policy Essay: Why We Must End Insurance Discrimination Against Mental Health Care." Harvard Journal on Legislation Vol. 44, No. 2. (Summer 2004) available at: *http://www.law.harvard.edu/students/orgs/jol/vol41_2/kennedy.php.* The French philosopher Rene Descartes' theory of dualism—the separation of mind and body—is seen as the non-scientific basis as to why people continue to believe having a mental illness is a personal failing, rather than a treatable disease. Descartes believed that while physicians had the ability to treat physical ailments, the mind, which implicated the spirit, could only be "treated" through religion.

[31] Id.

[32] Id.

[33] Id.

[34] Id.

[35] Id.

[36] Id.

[37] Id.

[38] Carter Testimony at 2.

[39] Shern Testimony at 2.

for any other illness. The discriminatory practices that have continued over forty years after the adoption of the first modern civil rights' laws attest to the deep-rootedness of stigma surrounding behavioral disorders.[40]

In 2004, more than 23 million people aged 12 or older required treatment for alcohol or illicit drug use but only 2.3 million received it.[41] For the 21.1 million who did not obtain treatment, cost and insurance barriers were cited as the primary obstacle.[42] In 2002, the Kaiser Family Foundation/Health Research and Educational Trust conducted an employer survey which found that while 98 percent of workers with employer-sponsored health insurance had coverage for mental health care, 74 percent of those covered workers were subject to an annual outpatient visit limit, and 64 percent were subject to an annual inpatient days limits.[43]

In her testimony before the House Energy and Commerce Committee hearing, Marley Prunty-Lara testified about her struggle with bipolar disorder and the difficulty she experienced when trying to get treatment. Prunty-Lara told of how she experienced firsthand the "harrowing, sinister, suicidal depression no one talks about."[44] However, as a 15-year-old with bipolar disorder, her mother struggled to find her treatment. Her state of South Dakota had limited mental health resources and the waiting list was four to five months to simply get an initial appointment. Prunty-Lara had to go 350 miles away to finally get treatment, however her treatment facility was not covered by her mother's insurance. Consequently, her parents were forced to take out a second mortgage on their home to pay for the life-saving treatment.[45]

Evidence demonstrates without adequate treatment, mental illnesses can continue or worsen in severity. Each year, 30,000 Americans take their lives, hundreds of thousands attempt to do so, and in ninety percent of these situations, the cause is untreated mental illness.[46]

The first federal mental health parity law

Congress took a first step toward ending discriminatory insurance practices with the enactment of the Mental Health Parity Act of 1996. As the first mental health parity law, MHPA sought to address the discrepancies in coverage between mental and other illnesses. The new law required employer-sponsored group health plans to abide by a set of new federal standards on mental health coverage. Specifically, the law prohibits employers from imposing annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical and surgical coverage.[47]

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[40] Id.
[41] National Institutes of Mental Health, supra note 25.
[42] Id.
[43] Henry J. Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET) national employer survey (2002).
[44] H.R. 1424, The Paul Wellstone Mental Health and Addiction Equity Act, hearing before the House Committee on Energy and Commerce, Subcommittee on Health, 110th Cong., 1st Sess., June 2007 (written testimony of Marley Prunty-Lara) [hereinafter Prunty-Lara Testimony].
[45] Id. at 1–2.
[46] The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) at 5 (written testimony of David Wellstone) [hereinafter Wellstone Testimony].
[47] General Accounting Office, supra note 22 at 3.

Through its adoption, significant progress has been made in the way of providing mental health coverage to those Americans suffering from a mental illness. During his testimony before the Education and Labor HELP Subcommittee on July 10, 2007, John Breyfogyle, testifying on behalf of the American Benefits Council, acknowledged that "better medical evidence on behavioral health conditions has become available and better treatment options have advanced during this period."[48]

While the 1996 Act represented an important milestone, it has not produced fundamental changes.[49] People with or at risk of behavioral-health disorders continue to face arbitrary discrimination in insurance plans. When reviewing the implementation of MHPA, GAO reported that the vast majority of issuers and group health plans it surveyed complied with the law, but substituted new restrictions and limitations on mental health benefits, thereby evading the letter of the law.[50] While the MHPA moved most employer plans toward parity in dollar limits for mental health coverage, the GAO reported that 87 percent of complying employers contained at least one other plan design feature that was more restrictive for mental health benefits than for medical and surgical benefits. Furthermore, one-fourth of employers did not comply, leaving their dollar limits unchanged.[51]

Loopholes in MHPA have created a system where employers routinely limit mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days and by imposing far higher cost sharing requirements.[52] These loopholes allow employers and insurance companies to deny mental health coverage to individuals and families most in need of it.[53] Consequently, individuals and families with adequate health care coverage will continue to watch their premiums increase as the uninsured and those with limited coverage continue to go to the emergency room to treat an illness that could have been cured at a far less cost if treated earlier in a doctor's office.

The Need to expand access to mental health care

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 asthma. 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.[54]

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[48] The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) at 1 (written testimony of John Breyfogyle) [hereinafter Breyfogyle Testimony].

[49] Shern Testimony at 2.

[50] General Accounting Office, supra note 22 at 21.

[51] Id.

[52] Id. at 13–14.

[53] Kennedy, supra note 30.

[54] 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.*

According to Congressman Patrick Kennedy, who testified at the HELP Subcommittee hearing on the "Paul Wellstone Mental Health and Addiction Equity Act" on July 10, 2007, it is estimated that:

> untreated mental health and addiction cost employers and society hundreds of billions of dollars in lost productivity. The World Health Organization has found that these diseases are far and away the most disabling diseases, accounting for more than a fifth of all lost days of productive life. Depressed workers miss 5.6 hours per week of productivity due to absenteeism and presenteeism, compared to 1.5 hours for non-depressed workers. Alcohol-related illness and premature death cost over $129.5 billion in lost productivity per year.[55]

Many U.S. business leaders fully understand the high returns wielded when investing in full mental health benefits for their employees. For example, James Hackett, the CEO of Ocean Energy, said that the increase in annual health costs to offer full parity between mental and physical health benefits is "more than offset by avoided costs of lost employee productivity."[56]

Gaps in coverage due to insurance discrimination

While considerable scientific evidence supports the claim that a separation between the mind and body does not exist, stigma and insurance discrimination continue to stand in the way for many Americans seeking access to adequate mental health coverage.[57] Despite the fact that former Surgeon General David Satcher wrote in his report on mental health in 1999 that the distinction between mind and body is arbitrary and not supported by science[58] and the National Institute of Mental Health continues to provide scientific evidence of the physiology of mental illness,[59] our country's insurance policies continue to perpetuate the stigma and discrimination surrounding mental illness.[60]

Employers and insurance companies routinely discriminate against mental health coverage when it comes to reimbursing individuals for their mental benefits. Insurers routinely 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

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[55] The Paul Wellstone Mental Health and Addiction Equity Act, hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) (written testimony of Rep. Patrick Kennedy) [hereinafter Kennedy Testimony].

[56] Kennedy, supra note 30 at 367.

[57] Id.

[58] SGRMH at 5–6.

[59] See, e.g., Nat'l Inst. of Mental Health, Schizophrenia Research 2 (May 2000) (noting that NIMH investigators have "recently discovered specific, subtle abnormalities in the structure and function of the brains of patients with schizophrenia"); Nat'l Inst. of Mental Health, Bipolar Disorder Research 4 (Apr. 2000), (concluding that "[o]ne of the most consistent findings to date has been the appearance of specific abnormalities, or lesions, in the white matter of the brain in patients with bipolar disorder"); Nat'l Institute of Mental Health, Anxiety Disorder Research 3 (August 1999) (finding that animal research suggests "different anxiety disorders may be associated with activation in different parts of the amygdala [a structure in the brain]").

[60] See GAO Report, supra note 22, at 12 (finding that more than a quarter of private health plans require greater cost-sharing for mental health care than physical health care); See also, Colleen L. Barry et al., Design of Mental Health Benefits: Still Unequal After All These Years, Health Affairs, Sept.–Oct. 2003, at 127, 129 (finding that 22% of private health plans have greater cost-sharing for mental health care).

that impose higher costs in at least one of these ways. Furthermore, 48 percent are enrolled in plans that impose all three limitations.[61]

In 2000, GAO found that issuers and group health plans provide more limited mental health coverage primarily because of cost concerns. Limits on hospital days, outpatient office visits, and annual or lifetime dollar amounts may reflect an issuer's concern about the high costs associated with long-term, intensive psychotherapy and extended hospital stays. Issuers may also restrict mental health benefits to protect themselves from perceived fears of adverse selection based on the argument that a plan with generous mental health benefits is more likely to attract a disproportionate number of individuals with a high demand for mental health services, and thus may drive up claims and premium costs of the plan.[62]

In his testimony before the Education and Labor HELP Subcommittee David Wellstone stated that in a "recent study of employer provided benefits . . . . the cost-sharing for addiction benefits was 46% higher for addiction benefits than for medical or surgical benefits and there were no out of pocket spending caps for addiction spending in 44% of the plans studied." [63]

Gaps in coverage due to the limited reach of state laws

The inequities in mental health coverage were first addressed by the states in the 1970s. In 1991, Texas and North Carolina were the first states to enact mental health parity legislation.[64] Today, 46 states have some type of mental health law but they vary considerably and can be divided into three categories: (1) mental health "full parity" or "equal coverage" laws; (2) minimum mandated mental health benefit laws; and (3) mandated mental health "offering laws." [65]

Full mental health parity laws prohibit insurers or group health plans from discriminating between coverage offered for mental illness, serious mental illness, substance abuse, and other physical disorders or diseases, and requires them to offer the same level of benefits across the board. "Full parity" means that an individual receives the same health care coverage for physical illnesses and mental health coverage, including treatment limitations and financial requirements.

Today, 28 states have laws that mandate full-parity mental health coverage.[66] Although mental health parity laws have increased coverage, they also have important limitations. Besides the fact that they do not apply to self-insured group health plans due to interpretations of ERISA's preemption clause,[67] these state full-parity laws seldom provide catastrophic coverage against the financial risk of severe mental illness.[68]

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[61] Colleen Barry et al., "Design of Mental Health Benefits: Still Unequal After All These Years," *Health Affairs,* September/October 2003.
[62] Id.
[63] Wellstone Testimony.
[64] Sundararaman, supra note 8.
[65] The National Conference of State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits," available at: *http://www.ncsl.org/programs.health.mentalben.htm.*
[66] Sundararaman, supra note 8 at 7.
[67] The National Conference of State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits," available at: *http://www.ncsl.org/programs.health.mentalben.htm.*
[68] Sundararaman, supra note 8 at 15.

In addition, state laws mandating full-parity differ in the types of mental illnesses and health plans they cover. In twelve of the states offering full-parity, the laws only apply to the treatment of all the conditions listed in the DSM–IV,[69] while the other state full-parity laws restrict coverage to specified "serious" or "biological based" mental illness. In fifteen of the states that offer full parity, the laws apply to both insured group and individual health plans, compared to nine states where the laws only apply to insured group health plans.

Six states have enacted minimum mandated benefit laws. These laws require "some" level of coverage be provided for mental illness, serious mental illness, substance abuse or a combination thereof. This is not considered full parity because these laws allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. These discrepancies can be in the form of different visit limits, co-payments, deductibles and annual lifetime limits.[70]

Fourteen states have enacted mandated offering laws. Mandated offering laws differ from the full-parity and minimum mandated benefit laws because they do not require that benefits be provided at all. Rather, they require that: (1) an option of coverage for mental illness, serious mental illness, substance abuse or a combination, be provided to the insured (this option can be accepted or rejected by the health service plan); and (2) if benefits are offered they must be equal.[71]

States with full-parity laws include Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Maine, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Virginia, Washington, and West Virginia. States with minimum mandated benefits include Alaska, Maryland, Michigan, Nevada, North Dakota, Oregon, Pennsylvania, Tennessee, and Texas. States providing mandated offering law include Alabama, Arizona, District of Columbia, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Mexico, Utah and Wisconsin.[72]

Mental health parity is cost-effective

Fair and equitable mental health treatment can be offered as part of a health benefit package without escalating costs. However, opponents of mental health parity often cite cost and an increased burden on employers as the reason to reject mental health parity. But as Representative Jim Ramstad noted in his testimony before the Education and Labor Committee, HELP Subcommittee, "expanding access to treatment is not only the right thing to do; it's also cost-effective . . . for the price of a cheap cup of coffee per

[69] The DSM–IV is a categorization of psychiatric diagnoses for all mental health disorders for both children and adults. The manual also lists known causes of these disorders, statistics in terms of gender, age at onset, and prognosis, as well as some research concerning the optimal treatment approaches. Mental health professionals use the DSM-IV when working with patients in order to better understand their illness and potential treatment and to help 3rd party payers (e.g., insurance providers) understand the needs of the patient. The book is typically considered the 'bible" for any professional who makes psychiatric diagnoses in the United States and many other countries. *See also: http://allpsych.com/disorders/dsm.html.*

[70] Sundararaman, supra note 8 at 7.

[71] The National Conference of State Legislatures, "State Laws Mandating or Regulating Mental Health Benefits," available at: *http://www.ncsl.org/programs.health.mentalben.htm.*

[72] Sundararaman, supra note 8 at 26.

month, sixteen million people in health plans could receive treatment for their mental illness or chemical addiction.[73]

In his testimony before the Energy and Commerce Committee, Subcommittee on Health, James Purcell, President and CEO of Blue Cross & Blue Shield of Rhode Island ("BCBSRI") testified about BCBSRI's efforts to integrate behavioral and physical health, as it is the future and so fundamental to complete care.[74] Purcell testified that not only is this the right thing to do, it is cost effective. The impact on claims costs of limiting annual coverage to fifteen visits rather than 30 visits would be approximately 0.3 percent of total claims."[75]

Numerous studies support the conclusion that while mental health parity imposes a nominal increase in costs to employers, it greatly benefits society as a whole. Stephen Melek, Bruce Pyenson, and Kathryn Fitch at Milliman Consultants and Actuaries issued a report on July 5, 2007 entitled, An Actuarial Analysis of the Impact of H.R. 1424. The study analyzed the estimated cost of implementing H.R. 1424.[76] By evaluating the approximate cost of implementing mental health parity in comparison to the cost of implementation if the organization implements utilization management (UM), where all benefit plans would choose to further tighten their degree of behavioral healthcare management.

The Milliman study projected that the cost increase for health insurance premiums would rise by between less than 0.1 percent and 0.6 percent, or between $0.03 and $2.40 per member per month. Employer contributions for health costs would rise by between less than 0.1 percent and 0.2 percent.[77] Utilization of facility-based behavioral healthcare services would increase by 9.7 percent, while professional services would increase by 30.0 percent without UM.[78] However, with UM, it projects a 21.3 percent decrease in use of facility-based services (the majority from mental health services) and a 3.1 percent increase for professional services. Member out-of-pocket costs for behavioral health services would decrease by 18 percent or about $0.20 per member per month without UM, reflecting balance between an increase in total out-of-pocket costs from higher service use by members under the higher parity benefit limits and a decrease in out-of-pocket costs per unit due to lower parity cost-sharing. For every 100,000 fully insured lives, member out-of-pocket costs are estimated to drop by $240,000 annually. Finally, the study estimates that administrative costs account for about 15 percent of the total increase, or $0.36 or less per member per month.[79]

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[73] The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) at 5 (written testimony of Rep. Jim Ramstad) [hereinafter Ramstad Testimony].

[74] H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act, hearing before the Energy and Commerce Committee, Subcommittee on Health, 110th Cong., 1st Sess. (2007) (written testimony of James E. Purcell) [hereinafter Purcell Testimony].

[75] Id. at 4.

[76] Stephen Melek, Bruce Pyenson, and Kathryn Fitch, An Actuarial Analysis of the Impact of H.R. 1424, "The Paul Wellstone Mental Health and Addiction Equity Act of 2007," (July 2007). See also, The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), hearing before the Subcommittee on Health, Employment, Labor, & Pensions, 110th Cong., 1st Sess. (2007) at 5 (written testimony of Stephen Melek) [hereinafter Melek Testimony].

[77] Id. at 3.

[78] Id.

[79] Id. at 4.

Howard Goldman testified before the Energy and Commerce Committee[80] about his work, including that contained within the "Surgeon General's Report on Mental Health," including his analysis of the cost of implementing the parity policy in the Federal Health Employee Benefit (FEHB) program. His research concluded that the policy was implemented smoothly and that plans did not drop out of the FEHB program. As a result, he further found that there was a significant decline in out-of-pocket spending in the FEHB plans compared to the non-parity plans. Goldman testified that this indicates parity coverage resulted in improved insurance protection against financial risks—the principal objective of health insurance. This savings to FEHB plan members was not associated with significant increases in use and spending attributable to parity. In fact, for the most part, increases in use and total spending in the FEHB plans were no greater than use and total spending increases in the comparison plans. This was true for adults, as well as for children and adolescents. The study concluded that parity of coverage of mental health and substance abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs.[81]

In the 2000 GAO report on mental health parity, GAO found that the federal parity law appears to have had a negligible effect on claims costs. Only about 3 percent of responding employers reported that compliance with the law increased their claim costs, and virtually no employers had dropped their mental health benefits or health coverage altogether since the law was enacted.[82] In addition, the CBO scored the Senate parity bill, S. 558 and concluded that there will be a nominal increase, approximately .4 percent,[83] in cost to a group health plan over the next ten years.

V. SECTION-BY-SECTION ANALYSIS

Title of the bill

Section 1. Provides that the short title of H.R. 1424 is the "Paul Wellstone Mental Health and Addiction Equity Act of 2007."

Amendments to the Employee Retirement Income Security Act of 1974

Section 2(a): Amends Employee Retirement Income Security Act of 1974 (ERISA) to require group health plans offering mental health and substance abuse coverage to apply the same treatment limitations to mental health and substance benefits as they do for medical and surgical benefits.

Section 2(a)(1) "(3)(C)": Categorizes the following items and services subject to mental health and substance-related treatment limit parity requirements (1) Inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network.

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[80] H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act, hearing before the House Committee on Energy and Commerce, Subcommittee on Health, 110th Cong., 1st Sess., June 2007 (written testimony of Dr. Howard Goldman) [hereinafter Goldman Testimony].

[81] Id.

[82] Government Accountability Office, supra note 22 at 6.

[83] CBO anticipates that approximately 60 percent of the .4 percent cost increase will be offset by employers changing the scope of benefits offered as a result of S. 558. The remaining 40 percent of the cost increase is expected to be covered by employees.

Section 2(a)(1) "(3)(C)(v)": Adds emergency care to the list of categories of items and services that are subject to the mental health and substance-related treatment limit parity requirements.

Section 2(a)(1) "(3)(D)": Defines "treatment limit" under a health plan as limitation on the number of visits or days of coverage, or other similar limit on the duration or scope of treatment.

Section 2(a)(1) "(4)(A)": Requires group health plan offering mental health benefits to apply the same financial limitations to mental health benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 2(a)(1) "(4)(B)": Requires group health plan offering substance-related benefits, to apply the same financial limitations to mental health benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 2(a)(1) "(4)(B)(iii)": Clarifies that nothing in this section prohibits a group health plan for waiving any deductible for mental health benefits and/or substance-related disorder benefits.

Section 2(b): Changes the term "mental health benefits" to "mental health or substance abuse-related disorder benefits."

Section 2(c): Makes available to a plan administrator the criteria for what is considered a medically necessary treatment for a mental illness or substance abuse disorder.

Section 2(d): Provides a minimum mental health and substance-related benefits package. If a group health plan offers mental health or substance-related benefits then it must cover the same range of mental illnesses and addiction disorders covered by the Federal Employee Health Benefit (FEHBP) plans 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.

Section 2(d) "(6)": With respect to out-of-network coverage, requires group health plans offering mental health and substance-related benefits, to apply the same coverage they offer for medical and surgical services to mental health and substance-related benefits

Section 2(e): Makes clear that group health plans may utilize benefit management practices for medical, surgical, mental health and substance related disorder benefits to the extent that these methods are recognized both by the industry and by providers and are not prohibited under applicable State laws.

Section 2(f): Provides an exemption to group health plans whose costs exceed 2% in the first plan year after initiation or 1% in each subsequent year.

Section 2(g): Provides an exemption for small employers with 50 or fewer employees, as well as employers who experience an increase in claim costs of at least 2% in the first plan year and 1% in subsequent years.

Section 2(i): Clarifies that nothing in this section preempts any State law that provides consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies

solely related to health insurance issuers except to the extent that such provision prevents the application of a requirement of this part.

Section 2(j): Conforms section 712 heading.

Section 2(k)(1): Makes the effective date of this section on or after January 1, 2008.

Section 2(k)(2): Makes clear that collectively bargained plans become subject to the act upon the expiration of the collective bargaining agreement or by January 1, 2010.

2(l): Requires the Department of Labor to annually sample and conduct random audits of group health plans to ensure compliance with the Act.

Section 3 amendments to the Public Health Service Act

Section 3(a)(1): Amends the Public Health Service Act to require group health plans offering mental health and substance abuse benefits to apply the same treatment limitations on mental health and substance abuse benefits as they do for medical and surgical benefits.

Section 3(a)(1) "(3)(C)": Categorizes the following items and services subject to mental health and substance-related treatment limit parity requirements (1) Inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out of network. Section 3(a)(1) "(3)(D)": Defines "treatment limit" under a health plan as limitation on the number of visits or days of coverage, or other similar limit on the duration or scope of treatment.

Section 3(a)(1) "(4)(A)": Requires group health plan offering mental health to apply the same financial limitations to mental health benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 3(a)(1) "(4)(B)": Requires group health plan offering substance-related coverage, to apply the same financial limitations to substance abuse benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 3(b): Changes the term "mental health benefits" to "mental health or substance abuse related disorder benefits."

Section 3(c): Makes available to a plan administrator the criteria for what is considered a medically necessary treatment for a mental illness or substance abuse disorder.

Section 3(d): Provides a minimum mental health and substance-related benefits package. If a group health plan offers mental health or substance-related benefits, then it must cover the same range of mental illnesses and addiction disorders covered by the Federal Employee Health Benefit (FEHBP) plans.

Section 3(d) "(6)(B)": With respect to out-of-network coverage, requires group health plans offering mental health and substance-related benefits, to apply the same coverage they offer for medical and surgical services to mental health and substance-related benefits.

Section 3(e): Provides an exemption for employers who experience an increase in claim costs of at least 2% in the first plan year and 1% in subsequent years.

Section 3(f): Provides an exemption for small employers with 50 or fewer employees.

Section 3(h): Clarifies that nothing in this section preempts any State law that provides greater consumer protections, benefits, methods of access to benefits, or rights or remedies.

Section 3(i): Conforms section 712 heading.

Section 3(j): Makes the effective date of this section on or after January 1, 2008.

Section 4 amendments to the Internal Revenue Code of 1986

Section 4(a): Amends the Internal Revenue Code to require group health plans offering mental health and substance abuse benefits to apply the same treatment limitations on mental health and substance abuse benefits as they do for medical and surgical benefits.

Section 4(a)(1) "(3)(C)": Categorizes the following items and services subject to mental health and substance-related treatment limit parity requirements (1) Inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out of network.

Section 4(a)(1) "(3)(D)": Defines "treatment limit" under a health plan as limitation on the number of visits or days of coverage, or other similar limit on the duration or scope of treatment.

Section 4(a)(1) "(4)(A)": Requires group health plan offering mental health to apply the same financial limitations to mental health benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 4(a)(1) "(4)(B)": Requires group health plan offering substance-related coverage, to apply the same financial limitations to substance abuse benefits as they do to medical and surgical benefits. This includes limits on deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. Plans are prohibited from establishing cost-sharing requirements that are specific to mental health benefits.

Section 4(b): Expands coverage of substance-related disorder benefits under the Internal Revenue Code.

Section 4(c): Makes available to a plan administrator the criteria for what is considered a medically necessary treatment for a mental illness or substance abuse disorder.

Section 4(d) "(6)(A)": Provides a minimum mental health and substance-related benefits package. If a group health plan offers mental health or substance-related benefits, then it must cover the same range of mental illnesses and addiction disorders covered by the Federal Employee Health Benefit (FEHBP) plans.

Section 4(d) "(6)(B)": Requires group health plans offering mental health and substance-related benefits, to apply the same out-of-network coverage they offer for medical and surgical services to mental health and substance-related benefits.

Section 4(e): Provides an exemption to employers who experience an increase in claim costs of at least 2% in the first plan year and 1% in subsequent years.

Section 4(f): Provides an exemption for small employers with 50 or fewer employees.

Section 4(h): Conforms section 712 heading.

Section 4(i): Makes the effective date of this section on or after January 1, 2008.

Section 5 Government Accountability Office studies and reports

Section 5(a): Requires the Comptroller General of the United States to conduct a study that evaluates implementation of the Paul Wellstone Mental Health and Addiction Equity Act. The study will analyze: (1) access to health insurance coverage; (2) the quality of such coverage, Medicare, Medicaid, and State and local mental health and substance abuse treatment spending; (3) the number of individuals with private insurance receiving publicly funded healthcare for mental health and substance-related disorders; (4) spending on public services such as the criminal justice system, special education, and income assistance programs; (5) the use of medical management of mental health and substance-related disorder benefits and medical necessity determinations by group health plans; (6) and any other matters the Comptroller General thinks appropriate. The report must be submitted to Congress two years after the enactment of H.R. 1424.

VI. Explanation of Amendments

The Amendment in the Nature of a Substitute is explained in the body of this report. Representative Kline introduced an amendment which would have substituted the Mental Health Parity Act (S. 558) for the Paul Wellstone Mental Health and Addiction Equity Act (H.R. 1424). The amendment was defeated 16–27.

VII. Application of Law to the Legislative Branch

Section 102(b)(3) of Public Law 104–1, the Congressional Accountability Act, requires a description of the application of this bill to the legislative branch. The Committee has determined that there is no legislative impact, since the Federal Employee Health Benefits (FEHB) program already provides parity for mental health care coverage pursuant to administrative rule making.

VIII. Regulatory Impact Statement

The Committee has determined that H.R. 1424 will have minimal impact on the regulatory burden.

IX. Unfunded Mandate Statement

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104–4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This issue is addressed in the CBO cost estimate letter.

X. Earmark Statement

H.R. 1424 does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e) or 9(f) of rule XXI.

XI. Roll Call

Insert offset folio 41 here HR374P1.001

Insert offset folio 42 here HR374P1.002

XII. Statement of Oversight Findings and Recommendations of the Committee

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

XIII. New Budget Authority and CBO Cost Estimate

With respect to the requirements of clause 3(c)(2) of rule XIII of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the Committee has received the following estimate for H.R. 1424 from the Director of the Congressional Budget Office:

U.S. Congress,
Congressional Budget Office,
Washington, DC, September 7, 2007.

Hon. George Miller,
Chairman, Committee on Education and Labor,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Shinobu Suzuki.

Sincerely,

Peter R. Orszag,
Director.

Enclosure.

H.R. 1424—Paul Wellstone Mental Health and Addiction Equity Act of 2007

Summary: H.R. 1424 would prohibit group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits (including benefits for substance abuse treatment) that are different from those used for medical and surgical benefits.

Enacting the bill would affect both federal revenues and direct spending for Medicaid, beginning in 2008. The bill would result in higher premiums for employer-sponsored health benefits. Higher premiums, in turn, would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, federal income and payroll tax revenues would decline. The Congressional Budget Office estimates that the proposal would reduce federal tax revenues by $1.1 billion over the 2008–2012 period and by $3.1 billion over the 2008–2017 period. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO

estimates that enacting H.R. 1424 would increase federal direct spending for Medicaid by $310 million over the 2008–2012 period and by $820 million over the 2008–2017 period. In addition, assuming appropriation of the necessary amounts, CBO estimates that implementing H.R. 1424 would have discretionary costs of $20 million in 2008, $143 million over the 2008–2012 period, and $322 million over the 2008–2017 period.

CBO has reviewed the non-tax provisions of the bill (sections 2, 3, and 5) and has determined that sections 2 and 3 contain intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would preempt state laws governing mental health coverage that conflict with those in this bill. However, because the preemption only would prohibit the application of state regulatory law, CBO estimates that the costs of the mandate to state, local, or tribal governments would not exceed the threshold established by UMRA ($66 million in 2007, adjusted annually for inflation).

As a result of this legislation, some state, local, and tribal governments would pay higher health insurance premiums for their employees. However, these costs would not result from intergovernmental mandates, but would be costs passed on to them by private insurers who would face a private-sector mandate to comply with the requirements of the bill.

The bill would impose a private-sector mandate on group health plans and group health insurance issuers by prohibiting them from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. Under current law, the Mental Health Parity Act of 1996 requires a more-limited form of parity between mental health and medical and surgical coverage. That mandate is set to expire at the end of 2007. Thus, H.R. 1424 would both extend and expand the existing mandate requiring mental health parity. CBO estimates that the direct costs of the private-sector mandate in the bill would total about $1.3 billion in 2008, and would grow in later years. That amount would significantly exceed the annual threshold established by UMRA ($131 million in 2007, adjusted for inflation) in each of the years that the mandate would be in effect.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1424 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

ESTIMATED BUDGETARY EFFECTS OF H.R. 1424

By fiscal year, in millions of dollars—	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008–2012	2008–2017
CHANGES IN REVENUES												
Income and HI Payroll Taxes (on-budget)	−20	−120	−170	−190	−210	−230	−250	−260	−280	−300	−710	−2,030
Social Security Payroll Taxes (off-budget)	−10	−70	−100	−100	−110	−120	−130	−140	−150	−160	−390	−1,090
Total Changes	−30	−190	−270	−290	−320	−350	−380	−400	−430	−460	−1,100	−3,120
CHANGES IN DIRECT SPENDING												
Medicaid:												
Estimated Budget Authority	30	60	70	70	80	90	90	100	110	120	310	820
Estimated Outlays	30	60	70	70	80	90	90	100	110	120	310	820
CHANGES IN SPENDING SUBJECT TO APPROPRIATION												
Implementation costs for DOL:												
Estimated Authorization Level	25	30	30	30	35	35	35	35	35	40	150	330
Estimated Outlays	20	29	30	30	34	35	35	35	35	39	143	322

Note: HI=Hospital Insurance (Part A of Medicare); DOL=Department of Labor.

Basis of estimate: H.R. 1424 would prohibit group health plans and group health insurance issuers who offer mental health benefits (including benefits for substance abuse treatment) from imposing treatment limitations or financial requirements for those benefits that are different from those used for medical and surgical benefits. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits. The provision would apply to benefits for any mental health condition that is covered under the group health plan.

The bill would not require plans to offer mental health benefits. It would, however, require that the mental health benefits of plans that choose to offer such benefits be at least as generous as the Federal Employees Health Benefits Plan (FEHBP) with the highest average enrollment as of the beginning of the most recent plan year involved. Existing laws in some states, however, require that plans cover all types of mental health services or ailments, which would reduce the potential impact of this bill on health plan premiums.

Revenues

The provisions of the bill would apply to both self-insured and fully insured group health plans. Small employers (those employing fewer than 50 employees in a year) would be exempt from the bill's requirements, as would individuals purchasing insurance in the individual market. The bill also would exempt group health plans for whom the cost of complying with the requirements would increase total plan costs (for medical and surgical benefits and mental health benefits) by more than 2 percent in the first plan year following enactment, and 1 percent in subsequent plan years. In general, H.R. 1424 would not preempt state laws regarding parity of mental health benefits except to the extent that state laws prohibit the application of a requirement of the bill.

CBO's estimate of the cost of this bill is based in part on published results of a model developed by the Hay Group. That model relies on data from several sources, including the claims experience of private health insurers and the Medical Expenditure Panel Survey. CBO adjusted those results to account for the current and future use of managed care arrangements for providing mental health benefits and the increased use of prescription drugs that mental health parity would be likely to induce. Also, CBO took account of the effects of existing state and federal rules that place requirements similar to those in the bill on certain entities. (For example, the Office of Personnel Management implemented mental health and substance abuse parity in the FEHBP in January 2001.)

CBO estimates that H.R. 1424, if enacted, would increase premiums for group health insurance by an average of about 0.4 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums that would likely be charged under the bill. Those responses would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored

insurance, changes in the types of health plans that are offered (including eliminating coverage for mental health benefits and/or substance benefits), and reductions in the scope or generosity of health insurance benefits, such as increased deductibles or higher copayments. CBO expects that those behavioral responses would offset 60 percent of the potential impact of the bill on total health plan costs.

The remaining 40 percent of the potential increase in costs—less than 0.2 percent of group health insurance premiums—would occur in the form of higher spending for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. State, local, and tribal governments are assumed to absorb 75 percent of the increase and to reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase. CBO estimates that the resulting reduction in taxable income would grow from $400 million in 2008 to $4.5 billion in 2017.

Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by $30 million in 2008 and by $3.1 billion over the 2008–2017 period if H.R. 1424 were enacted. Social Security payroll taxes, which are off-budget, would account for about 35 percent of those totals.

Direct spending

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting H.R. 1424 would increase Medicaid payments to managed care plans by about 0.2 percent. That is less than the 0.4 percent increase in the estimated increase in spending for employer-sponsored health insurance because Medicaid programs offer broader coverage of mental health benefits than the private sector. CHO estimates that enacting H.R. 1424 would increase federal spending for Medicaid by $310 million over the 2008–2012 period and $820 million over the 2008–2017 period.

Spending subject to appropriation

H.R. 1424 would require the Secretary of Labor to provide assistance to participants and beneficiaries of group health plans and conduct random audits of plans to ensure that they are in compliance with the requirements of the bill. The bill also would require the Secretary to submit a biennial report on obstacles that individuals face in obtaining care for mental health and substance related disorders. Based on the costs of implementing the Health Insurance Portability and Accountability Act of 1996, and assuming appropriation of the necessary amounts, CBO estimates that implementing H.R. 1424 would incur discretionary costs of $20 million in 2008 and $30 million to $40 million annually in subsequent years.

Estimated impact on state, local, and tribal governments: H.R. 1424 would preempt state laws governing mental health coverage that conflict with those in this bill. That preemption would be an intergovernmental mandate as defined in UMRA. However, be-

cause the preemption would simply prohibit the application of state regulatory laws that conflict with the new federal standards, CBO estimates that the mandate would impose no significant costs on state, local, or tribal governments.

An existing provision in the Public Health Service Act (PHSA) would allow state, local, and tribal governments, as employers that provide health benefits to their employees, to opt out of the requirements of this bill. Consequently, the bill's requirements for mental health parity would not be intergovernmental mandates as defined in UMRA, and the bill would affect the budgets of those governments only if they choose to comply with the requirements on group health plans. Roughly two-thirds of employees in state, local, and tribal governments are enrolled in self-insured plans.

The remaining governmental employees are enrolled in fully insured plans. Governments purchase health insurance for those employees through private insurers and would face increased premiums as a result of higher costs passed on to them by those insurers. The increased costs, however, would not result from intergovernmental mandates. Rather, they would be part of the mandate costs initially borne by the private sector and then passed on to the governments as purchasers of insurance. CBO estimates that state, local, and tribal governments would face additional costs of about $10 million in 2008, increasing to about $155 million in 2012. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

Because the bill's requirements would apply to managed care plans in the Medicaid program, CBO estimates that state spending for Medicaid also would increase by about $235 million over the 2008–2012 period.

Estimated impact on the private sector: The bill would impose a private-sector mandate on group health plans and issuers of group health insurance that provide medical and surgical benefits as well as mental health benefits (including benefits for substance abuse treatment). H.R. 1424 would prohibit those entities from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. The requirements would not apply to coverage purchased by employer groups with fewer than 50 employees. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would be established by comparing in-network medical and surgical benefits with in-network mental health benefits, and comparing out-of-network medical and surgical benefits with out-of-network mental health benefits.

Under current law, the Mental Health Parity Act of 1996 prohibits group health plans and group health insurance issuers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on medical and surgical coverage. The current mandate is set to expire at the end of calendar year 2007. Consequently, H.R. 1424 would both extend and expand the current mandate requiring mental health parity.

CBO's estimate of the direct costs of the mandate assumes that affected entities would comply with H.R. 1424 by further increasing the generosity of their mental health benefits, Many plans currently offer mental health benefits that are less generous than

their medical and surgical benefits. We estimate that the direct costs of the additional services that would be newly covered by insurance because of the mandate would equal about 0.4 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

CBO estimates that the direct costs of the mandate in H.R. 1424 would be $1.3 billion in 2008, rising to $3.0 billion in 2012. Those costs would exceed the threshold specified in UMRA ($131 million in 2007, adjusted annually for inflation) in each year the mandate would be in effect,

Previous CBO estimate: On March 20, 2007, CBO transmitted a cost estimate for S. 558, the Mental Health Parity Act of 2007, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions on February 14, 2007. H.R. 1424 differs from S. 558 in several ways: (1) it would require mental health benefits of plans that choose to offer such benefits be at least as generous as FEHBP with the highest average enrollment as of the beginning of the most recent plan year involved; (2) it would exempt group health plans with collective bargaining agreements from the requirements of the bill until the later of the expiration of such agreements or January 1, 2010; (3) it would make conforming modifications to the Internal Revenue Code (IRC); and (4) the provisions of H.R. 1424 would apply to group health plans beginning January 1, 2008, while S. 558 specified that the policy would be effective more than one year after the date of the enactment, affecting plans beginning on or after January 1, 2009.

CBO estimates the minimum benefit requirement and exception for the collective bargaining agreements would have no significant budgetary effect, while the difference in the effective dates would affect our estimate in 2008 and 2009. CBO and the Joint Committee on Taxation estimate that conforming modifications to the IRC would result in a negligible excise tax revenue collected from employers who fail to comply with the requirements of the bill.

Estimate prepared by: Federal Costs: Jeanne De Sa and Shinobu Suzuki; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

XIV. Statement of General Performance Goals and Objectives

In accordance with clause 3(c) of House rule XIII, the goal of H.R. 1424 is to increase access to mental health treatment and to prevent health insurance providers and employers from discriminating against individuals on the basis of mental illness.

XV. Constitutional Authority Statement

Under clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee must include a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by H.R. 1424. The amendments made by this bill 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 require-

ments (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. The Committee believes these amendments are within Congress' authority under Article I, Section 8, Clauses 1 and 3 of the Constitution.

XVI. COMMITTEE ESTIMATE

Clause 3(d)(2) of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison of the costs that would be incurred in carrying out H.R. 1424. However, clause 3(d)(3)(B) of that rule provides that this requirement does not apply when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 402 of the Congressional Budget Act.

XVII. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

* * * * * * *

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Employee Retirement Income Security Act of 1974".

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY

Sec. 701. Increased portability through limitation on

* * * * * * *

SUBPART B—OTHER REQUIREMENTS

Sec. 711. Standards relating to benefits for mothers and newborns.
[Sec. 712. Parity in the application of certain limits to mental health benefits.]
Sec. 712. Equity in mental health and substance-related disorder benefits.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

* * * * * * *

[SEC. 712. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.]

SEC. 712. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED 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 benefits**]** *mental health or substance-related disorder benefits*—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on **[**mental health benefits**]** *mental health or substance-related 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 benefits**]** *mental health or substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and **[**mental health benefits**]** *mental health or substance-related disorder benefits*; or

(ii) not include any aggregate lifetime limit on **[**mental health benefits**]** *mental health or substance-related 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 benefits**]** *mental health or substance-related 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 benefits**]** *mental health or substance-related 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 benefits] *mental health or substance-related 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 benefits] *mental health or substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and [mental health benefits] *mental health or substance-related disorder benefits*; or

(ii) not include any annual limit on [mental health benefits] *mental health or substance-related 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 benefits] *mental health or substance-related 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) TREATMENT LIMITS.—

(A) NO TREATMENT LIMIT.—If the plan or coverage does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose any treatment limit on mental health or substance-related disorder benefits that are classified in the same category of items or services.

(B) TREATMENT LIMIT.—If the plan or coverage includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose such a treatment limit on mental health or substance-related disorder benefits for items and services within such category that is more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following five categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

(i) INPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

(ii) INPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

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

(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

(v) 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 condition relating to mental health and substance-related disorders).

(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term "treatment limit" means, with respect to a plan or coverage, 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 or coverage.

(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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 limit or requirement with respect to such category of items and services.

(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan or coverage does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified under paragraph (3)(C)), the plan or coverage may not impose such a beneficiary financial requirement on mental health or substance-related disorder benefits for items and services within such category.

(B) BENEFICIARY FINANCIAL REQUIREMENT.—

(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 (as specified in paragraph (3)(C)), the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for

such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage 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 predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as prohibiting the plan or coverage from waiving the application of any deductible for mental health benefits or substance-related disorder benefits or both.

(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term "beneficiary financial requirement" includes, with respect to a plan or coverage, 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 or coverage, but does not include the application of any aggregate lifetime limit or annual limit.

(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) 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 and substance-related disorder benefits in the case of any participant or beneficiary shall, upon request, be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.

(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition and

substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

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

(i) IN GENERAL.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

(I) 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).

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

(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.

(7) CONSTRUCTION.—Nothing in this section shall be construed to limit a group health plan (or health insurance offered in connection with such a plan) from managing the provision of medical, surgical, mental health or substance-related disorder benefits through any of the following methods:

(A) the application of utilization review;

(B) the application of authorization or management practices;

(C) the application of medical necessity and appropriateness criteria; or

(D) other processes intended to ensure that beneficiaries receive appropriate care and medically necessary services for covered benefits;

to the extent such methods are recognized both by industry and by providers and are not prohibited under applicable State laws.

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

[(1) as requiring] *construed as requiring* a group health plan (or health insurance coverage offered in connection with such a plan) to provide any [mental health benefits; or] *mental health or substance-related disorder benefits.*

[(2) 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).]

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—

(A) * * *

(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 [and who employs at least 2 employees on the first day of the plan year].

* * * * * * *

[(2) INCREASED COST EXEMPTION.—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.]

(2) INCREASED 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-related 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.

(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

(i) 2 percent in the case of the first plan year which begins after the effective date of the amendments made by section 101 of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 subsection shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with such a 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.—An election to modify coverage of mental health and substance-related disorder benefits as permitted under this paragraph shall be treated as a material modification in the terms of the plan as described in section 102(a) and notice of which shall be provided a reasonable period in advance of the change.

(F) NOTIFICATION OF APPROPRIATE AGENCY.—

(i) IN GENERAL.—A group health plan that, based on upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall notify the Department of Labor of such election.

(ii) REQUIREMENT.—A notification 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-related 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-related disorder benefits under the plan.

(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Department of Labor shall make available, upon request to the appropriate committees of Congress 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 any type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(G) NO IMPACT ON APPLICATION OF STATE LAW.—The fact that a plan or coverage is exempt from the provisions of this section under subparagraph (A) shall not affect the application of State law to such plan or coverage.

* * * * * * *

(e) DEFINITIONS.—For purposes of this section—

(1) * * *

* * * * * * *

(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 benefits⟧ *mental health or substance-related disorder benefits*.

(4) ⟦MENTAL HEALTH BENEFITS⟧ *MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS*.—The term "⟦mental health benefits⟧ *mental health or substance-related disorder benefits*" means ⟦benefits with respect to mental health services⟧ *benefits with respect to services for mental health conditions or substance-related disorders*, 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⟧.

⟦(f) SUNSET.—This section shall not apply to benefits for services furnished after December 31, 2007.⟧

(f) PREEMPTION, RELATION TO STATE LAWS.—

(1) IN GENERAL.—This part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance issuers in connection with group health insurance coverage (including benefit mandates or regulation of group health plans of 50 or fewer employees) except to the extent that such provision prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

(3) OTHER STATE LAWS.—Nothing in this section shall be construed to exempt or relieve any person from any laws of any State not solely related to health insurance issuers in connection with group health coverage insofar as they may now or hereafter relate to insurance, health plans, or health coverage.

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SECTION 2705 OF THE PUBLIC HEALTH SERVICE ACT

[SEC. 2705. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.]

SEC. 2705.

(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 benefits**]** *mental health and substance-related disorder benefits*—

(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on **[**mental health benefits**]** *mental health and substance-related 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 benefits**]** *mental health and substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and **[**mental health benefits**]** *mental health and substance-related disorder benefits*; or

(ii) not include any aggregate lifetime limit on **[**mental health benefits**]** *mental health and substance-related 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 benefits**]** *mental health and substance-related 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 benefits**]** *mental health and substance-related 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 benefits**]** *mental health and substance-related 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 benefits] *mental health and substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and [mental health benefits] *mental health and substance-related disorder benefits*; or

(ii) not include any annual limit on [mental health benefits] *mental health and substance-related 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 benefits] *mental health and substance-related 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) TREATMENT LIMITS.—

(A) NO TREATMENT LIMIT.—If the plan or coverage does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services (specified in subparagraph (C)), the plan or coverage 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.

(B) TREATMENT LIMIT.—If the plan or coverage includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan or coverage may not impose such a treatment limit on mental health and substance-related disorder benefits for items and services within such category that are more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following four categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

(i) INPATIENT, IN-NETWORK.—Items and services furnished on an inpatient basis and within a network of

providers established or recognized under such plan or coverage.

(ii) INPATIENT, OUT-OF-NETWORK.—Items and services furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

(iii) OUTPATIENT, IN-NETWORK.—Items and services furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term "treatment limit" means, with respect to a plan or coverage, 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 or coverage.

(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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 limit or requirement with respect to such category of items and services.

(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan or coverage does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified in paragraph (3)(C)), the plan or coverage may not impose such a beneficiary financial requirement on mental health and substance-related disorder benefits for items and services within such category.

(B) BENEFICIARY FINANCIAL REQUIREMENT.—

(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement

not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage may not impose such financial requirement on mental health and substance-related disorder benefits for items and services within such category in a way that is more costly to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term "beneficiary financial requirement" includes, with respect to a plan or coverage, 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 or coverage, but does not include the application of any aggregate lifetime limit or annual limit.

(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related 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) 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 and substance-related disorder benefits in the case of any participant or beneficiary shall, upon request, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.

(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

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

(i) IN GENERAL.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health and substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related dis-

order benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

(I) 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 and substance-related disorders).

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

(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.

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

⟦(1) as requiring⟧ *construed as requiring* a group health plan (or health insurance coverage offered in connection with such a plan) to provide any ⟦mental health benefits; or⟧ *mental health and substance-related disorder benefits.*

⟦(2) 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).⟧

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—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.

⟦(2) INCREASED COST EXEMPTION.—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.⟧

(2) INCREASED 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-related 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.

(B) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with such a 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.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the Employee Retirement Income Security Act of 1974 with respect to the a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.

* * * * * * *

(e) DEFINITIONS.—For purposes of this section—

(1) * * *

* * * * * * *

(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 benefits**]** *mental health and substance-related disorder benefits*.

(4) **[**MENTAL HEALTH BENEFITS**]** *MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS*.—The term "**[**mental health benefits**]** *mental health and substance-related disorder benefits*" means **[**benefits with respect to mental health serv-

ices] *benefits with respect to services for mental health conditions or substance-related disorders*, 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.

[(f) SUNSET.—This section shall not apply to benefits for services furnished after December 31, 2007.]

(f) PREEMPTION, RELATION TO STATE LAWS.—

(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies that are greater than the protections, benefits, methods of access to benefits, rights or remedies provided under this section.

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

INTERNAL REVENUE CODE OF 1986

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter B—Other Requirements

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[Sec. 9812. Parity in the application of certain limits to mental health benefits.]
Sec. 9812. Equity in mental health and substance-related disorder benefits.

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[SEC. 9812. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.]

SEC. 9812. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan that provides both medical and surgical benefits and [mental health benefits] *mental health and substance-related disorder benefits*—

(A) NO LIFETIME LIMIT.—If the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on [mental health benefits] *mental health and substance-related disorder benefits*.

(B) LIFETIME LIMIT.—If the plan includes an aggregate lifetime limit on substantially all medical and surgical

benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan 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 benefits] *mental health and substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and [mental health benefits] *mental health and substance-related disorder benefits*; or

(ii) not include any aggregate lifetime limit on [mental health benefits] *mental health and substance-related disorder benefits* that is less than the applicable lifetime limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan 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 with respect to [mental health benefits] *mental health and substance-related 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 that provides both medical and surgical benefits and [mental health benefits] *mental health and substance-related disorder benefits*—

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

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

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to [mental health benefits] *mental health and substance-related disorder benefits* and not distinguish in the application of such limit between such medical and surgical benefits and [mental health benefits] *mental health and substance-related disorder benefits*; or

(ii) not include any annual limit on [mental health benefits] *mental health and substance-related disorder benefits* that is less than the applicable annual limit.

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan 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 with respect to [mental health benefits]

mental health and substance-related 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) TREATMENT LIMITS.—

(A) NO TREATMENT LIMIT.—If the plan does not include a treatment limit (as defined in subparagraph (D)) on substantially all medical and surgical benefits in any category of items or services (specified in subparagraph (C)), 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.

(B) TREATMENT LIMIT.—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 and substance-related disorder benefits for items and services within such category that are more restrictive than the predominant treatment limit that is applicable to medical and surgical benefits for items and services within such category.

(C) CATEGORIES OF ITEMS AND SERVICES FOR APPLICATION OF TREATMENT LIMITS AND BENEFICIARY FINANCIAL REQUIREMENTS.—For purposes of this paragraph and paragraph (4), there shall be the following four categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance related benefits shall be classified into one of the following categories:

(i) INPATIENT, IN-NETWORK.—Items and services furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

(ii) INPATIENT, OUT-OF-NETWORK.—Items and services furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

(iii) OUTPATIENT, IN-NETWORK.—Items and services furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term "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.

(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or 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

limit or requirement with respect to such category of items and services.

(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a category of items and services (specified in paragraph (3)(C)), the plan may not impose such a beneficiary financial requirement on mental health and substance-related disorder benefits for items and services within such category.

(B) BENEFICIARY FINANCIAL REQUIREMENT.—

(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage 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 or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan includes a beneficiary financial requirement not described in clause (i) 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 and substance-related disorder benefits for items and services within such category in a way that is more costly to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term "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, but does not include the application of any aggregate lifetime limit or annual limit.

(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits shall be made available by the plan administrator to any current or potential participant, beneficiary, or contracting 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 shall, upon request, be made available by the plan administrator to the participant or beneficiary.

(6) MINIMUM SCOPE OF COVERAGE AND EQUITY IN OUT-OF-NETWORK BENEFITS.—

(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, 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.

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

(i) IN GENERAL.—In the case of a plan that provides both medical and surgical benefits and mental health and substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall 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 of this section.

(ii) CATEGORIES OF ITEMS AND SERVICES.—For purposes of clause (i), there shall be the following three categories of items and services for benefits, whether medical and surgical benefits or mental health and substance-related disorder benefits, and all medical and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:

(I) 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 and substance-related disorders).

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

(III) OUTPATIENT.—Items and services not described in subclause (I) furnished on an outpatient basis.

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

[(1) as requiring] *construed as requiring* a group health plan to provide any [mental health benefits; or] *mental health and substance-related disorder benefits.*

[(2) in the case of a group health 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, 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).]

(c) EXEMPTIONS.—

[(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan for any plan year of a small employer (as defined in section 4980D(d)(2)).

[(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan if the application of this section to such plan results in an increase in the cost under the plan of at least 1 percent.]

(1) SMALL EMPLOYER EXEMPTION.—

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

(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term "small employer" means, 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. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.

(2) INCREASED COST EXEMPTION.—

(A) IN GENERAL.—With respect to a group health plan, if the application of this section to such plan 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-related 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 during the following plan year, and such exemption shall apply to the plan for 1 plan year.

(B) APPLICABLE PERCENTAGE.—With respect to a plan, the applicable percentage described in this paragraph shall be—

(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; 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 for purposes of this subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

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

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(e) DEFINITIONS.—For purposes of this section:

(1) * * *

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(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, but does not include [mental health benefits] *mental health and substance-related disorder benefits*.

(4) [MENTAL HEALTH BENEFITS] *MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS*.—The term "[mental health benefits] *mental health and substance-related disorder benefits*" means [benefits with respect to mental health services] *benefits with respect to services for mental health conditions or substance-related disorders*, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

[(f) APPLICATION OF SECTION.—THIS SECTION SHALL NOT APPLY TO BENEFITS FOR SERVICES FURNISHED—

[(1) on or after September 30, 2001, and before January 10, 2002,

[(2) on or after January 1, 2004, and before the date of the enactment of the Working Families Tax Relief Act of 2004, and

[(3) after December 31, 2007.]

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XIII. COMMITTEE CORRESPONDENCE

None.

MINORITY VIEWS

INTRODUCTION

The goal of providing parity between mental health benefits and other medical benefits provided under employer-sponsored health coverage is something that all Members of the Committee and, we believe, most Members of Congress, would endorse. In the 110th Congress, competing legislative proposals in the House and Senate offer substantially different approaches in addressing this issue. It is our belief that the proposal advancing in the Senate is a far superior one to that of the House. Accordingly, we set forth these views to express our concerns with the House bill, and urge that as the legislative process moves forward, the House brings its efforts in line with that of the other body.

As a principal committee of jurisdiction, the Committee on Education and Labor has long been involved in the mental health parity debate. Full mental health parity bills have been introduced in prior Congresses but have not been enacted into law, largely because of the serious concerns associated with these proposals and the opposition to imposition of additional federal coverage mandates on employers, who continue to struggle to provide affordable, high-quality coverage to their employees. In the 110th Congress, mental health parity legislation is moving closer toward passage.

The current parity bills, H.R. 1424 in the House and S. 558 in the Senate, represent two significantly different approaches to the issue of achieving mental health parity in employer-sponsored coverage. H.R. 1424, as reported by the Committee, more closely reflects prior failed efforts—it involved virtually no input from those parties responsible for complying with the mandates (employers, insurers, e.g.), and is, not surprisingly, strongly opposed by those parties. In stark contrast, the Senate bill, S. 558, reflects a carefully negotiated consensus of all major stakeholders on all sides of the mental health parity debate.

Members on both sides of the aisle can in good conscience and good faith disagree on the merits of both pending bills. However, there can be little legitimate debate that the Senate bill, offered as the Republican Substitute at full Committee markup on July 18, 2007 by Representative John Kline, is the only proposal that achieves exactly what all parties purportedly intend: full parity between mental health and other medical benefits. H.R. 1424, in contrast, grants preferential treatment for mental health benefits and as such, constitutes bad policy. Accordingly, and for the reasons set forth below, we oppose its passage.

FEDERAL LAW ON THE PROVISION OF MENTAL HEALTH BENEFITS

The provision of health benefits by employers to their employees is generally governed by the Employee Retirement Income Security

Act ("ERISA"). In 1996, Congress enacted the Mental Health Parity Act ("MHPA"), which amended ERISA and established new federal standards for mental health coverage offered by group health plans.[1] The MHPA added section 712 of ERISA to create certain requirements for mental health coverage, if this coverage was offered by a health plan. Under the MHPA, health plans are not required to offer mental health benefits. However, plans that do choose to provide mental health benefits are prohibited from imposing lower annual and lifetime dollar limits on these benefits than the limits placed on medical and surgical benefits. Under current law, the MHPA's parity requirements do not apply to substance abuse or chemical dependency treatment.

The MHPA's standards apply only to private-sector, employer-sponsored group health plans, including both fully-insured and self-insured plans, but not to the individual (non-group) health insurance market. Employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families, including cost sharing and requirements relating to medical necessity. Also, certain plans may be exempt from the MHPA. For instance, a small employer exception provides that plans covering employers with 50 or fewer employees are exempt from compliance. In addition, the MHPA permits employers to "opt-out" of the MHPA's requirements if they experience an increase in claims costs of at least one percent as a result of compliance. The provisions of the MHPA were originally set to expire in 2001, but have been routinely reauthorized on an annual basis, with the current authorization expiring on December 31, 2007.

EXECUTIVE ACTION ON MENTAL HEALTH PARITY

In 1999, President Clinton issued an executive order that implemented full parity for both mental health and substance abuse benefits in health plans offered under the Federal Employees Health Benefits Program (FEHBP) beginning in 2001. These benefits cover all medically necessary treatments for all categories of mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV).[2] Under the FEHBP, mental health parity is required only for services provided on an in-network basis (i.e., through a specific group of providers contracted by a managed health care organization and/or an insurance carrier to provide services to participants in that particular plan). Further, the FEHBP plans engage in medical management practices to ensure appropriate diagnosis and treatment of mental health conditions.[3]

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[1] On the state level, all states except Wyoming have passed mental health parity laws which require state law-governed health plans to provide varying degrees of mental health coverage, subject these plans to certain financial limits, or otherwise mandate mental health benefits. Employers with fully-insured and self-insured plans that are regulated under ERISA (and thus the MHPA) are not bound by these state laws, and therefore not subject to these state mandates. Thus, actions taken by the Committee to amend ERISA will, of necessity, have far-reaching consequences.

[2] The Diagnostic and Statistical Manual of Mental Disorders is produced by the American Psychiatric Association and is a comprehensive system of diagnosis for psychiatric conditions. The fourth (IV) edition was published in 1995, and is the most current edition.

[3] In general, the term "medical management" is used to describe practices designed to ensure appropriate diagnosis and treatment of medical conditions, and to improve efficiency and quality in the delivery of medical services. Such practices include utilization review, case management, disease management, and quality management.

The Office of Personnel Management estimated that implementation of the order resulted in an average premium increase of 1.64 percent for fee-for-service plans and 0.3 percent for HMOs.

While endorsing in principle the concept of mental health parity, the current Administration has not yet endorsed any particular bill, including H.R. 1424 or S. 558.

FEDERAL LEGISLATIVE ACTIVITY

Senate legislation

In the 110th Congress, the Mental Health Parity Act of 2007, S. 558, was introduced by Senators Pete Domenici (R–NM), Ted Kennedy (D–MA), and Mike Enzi (R–WY) on February 12, 2007. The Senate Health, Education, Labor, and Pensions ("HELP") Committee approved the measure, as amended, on February 14, 2007. The Senate bill was the product of negotiations between patient advocates, behavioral health providers, insurers, and business groups (collectively, the "Fairness Coalition").[4]

S. 558 generally requires health insurance plans that offer mental health coverage to provide that coverage on par with financial and treatment coverage offered for other physical illnesses, The Senate bill would not mandate that plans provide specific mental health benefits; however, fully insured plans, which remain subject to state insurance laws, would still be required to comply with state-specific benefit requirements. S. 558 also would specifically ensure that medical management of mental health benefits and negotiation of separate reimbursement or provider payment rates is not prohibited, meaning that employers and health plans could maintain flexibility in forming behavioral health care provider networks. Finally, the Senate bill, as introduced, would preempt state parity laws that could impact fully-insured plans governed by ERISA, but would largely leave benefit mandates intact.

The Congressional Budget Office ("CBO") scored S. 558 and concluded that it would result in a 0.4 percent increase in employer-sponsored premiums. This was estimated to amount to $1.5 billion in 2009 and $3.4 billion in 2013. Also, for the five-year period 2008–2012, CBO estimated a $1 billion decrease in direct revenues (resulting from increased premium deductions), $280 million in increased direct spending (Medicaid managed care), and $150 million in increased appropriations.[5]

Additional discussions and negotiations involving S. 558 have continued subsequent to the HELP Committee's markup, and have resulted in slight revisions to S. 558 as reported out of committee in the form of a proposed "manager's amendment" for Senate Floor consideration. However, this has not changed the support of the Fairness Coalition for that bill. In fact, the parties that negotiated the manager's amendment sent the following letter to Senators Kennedy, Enzi, and Domenici:

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[4] Members of the Fairness Coalition include the following health care provider and mental health advocacy groups: the American Hospital Association, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Association for Behavioral Health and Wellness, the Federation of American Hospitals, Mental Health America, National Alliance on Mental Illness, and the National Association of Psychiatric Health Systems.

[5] See, Congressional Budget Office, Cost Estimate, S. 558 Mental Health Parity Act of 2007, dated March 20, 2007.

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All but two of the provider and advocacy groups of the Fairness Coalition involved in the negotiation of the Senate manager's amendment—Mental Health America and the American Medical Association—signed the June 14 letter above; however, those two groups have not withdrawn their support for the Senate manager's amendment.

House Legislation

On March 7, 2007, Representatives Patrick Kennedy (D–RI) and Jim Ramstad (R–MN) introduced H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. This bill amends ERISA, the Public Health Service Act, and the Internal Revenue Code, and was referred to the Committees on Education and Labor, Energy and Commerce, and Ways and Means, As a matter of policy, the bill raises a number of substantive concerns.

As introduced, H.R.. 1424 purports to achieve mental health parity by prohibiting treatment limits or the imposition of financial requirements on mental health and substance-related disorder benefits within group health plans if those requirements and limitations are not similarly imposed on medical and surgical benefits under such plans. The bill would impose a further, broad mandate by requiring that where a plan covers any behavioral health disorder, it must cover all currently recognized conditions listed in the DSM–IV. This mandate would include requiring coverage for certain disorders, such as "caffeine intoxication" and "circadian rhythm sleep disorder (jet lag)." H.R. 1424 eliminates a plan's flexibility to determine covered benefits. Under the bill, plans would not be specifically permitted to engage in medical management practices and negotiate separate reimbursement or provider payment rates. H.R. 1424 would mandate out-of-network coverage for mental health and substance-related disorders, if such coverage is provided for emergency, inpatient or outpatient services.

Finally, and perhaps most importantly, on the issue of ERISA preemption, H.R. 1424 would give states the authority to enact greater consumer protections, benefits, methods of access to benefits, rights or remedies than those contained in the federal bill. The bill, if enacted, would establish a benefit "floor" while permitting states to impose broader mental health coverage mandates, creating inconsistent and confusing regulatory schemes. At the same time, this provision allows state enforcement and remedy schemes to be established which would apply to certain fully-insured plans, only for mental health benefits but not other medical benefits. Such plans have operated under the exclusive jurisdiction and remedies set forth under ERISA, which has existed and has been interpreted by the courts for over three decades.

CBO has not scored H.R. 1424. However, considering the CBO score for S. 558 and the broader employer mandate set forth in H.R. 1424, it is likely that H.R. 1424's costs would meet or exceed those of the Senate bill.

Legislative hearing on H.R. 1424

On July 10, 2007, the Committee on Education and Labor Subcommittee on Health, Education, Labor, and Pensions held a legislative hearing on H.R. 1424. At that hearing, Representatives Ken-

nedy and Ramstad testified, as did Former First Lady Rosalyn Carter, mental health advocates, an economic analyst, and the Commissioner of Insurance for the State of Wisconsin. Additional witnesses included Jon Breyfogle, an attorney that represented the American Benefits Council, and E. Neil Trautwein, who represented the National Retail Federation ("NRF"). The hearing focused on the specific provisions of the House bill, but also featured robust discussion of the Senate proposal.

Mr. Trautwein testified as to why the NRF opposes H.R. 1424, but also as to the reasons why that group supports the proposed manager's amendment to S. 558. In his testimony, Mr. Trautwein raised a number of concerns regarding the provisions of H.R. 1424, including its broad coverage mandate, ERISA preemption and the role of the states, inadequate medical management protections, and the mandate to provide out-of-network coverage. Importantly, he outlined the collaborative Senate process that resulted in a balanced parity bill. In his own words:

> The mental health parity debate has been both long and fierce. have been an advocate in this debate for a number of years, both before and after the 1996 law addressing parity in annual and lifetime limits. We all have contributed heated rhetoric to this debate. Unfortunately, it has really obscured our shared objective of helping individuals get the coverage and care they needed.
>
> It is this last point that has encouraged a running dialogue between the advocates and Senate sponsors. *I have been privileged to have participated over a number of years as a principal representative of the employer community in intense discussions and negotiations with both the Senate sponsors as well as advocates for the mental health and addiction communities. I would like to give special thanks to Senators Ted Kennedy (D–MA), Michael Enzi (R–WY) and Pete Domenici (R–NM) for their longstanding advocacy on this legislation as well as for their willing ear and fair and responsive negotiations through the years.*
>
> *The Senate compromise that I have highlighted throughout this testimony is the product of those negotiations. It has also created a broad coalition among erstwhile opponents—surely somewhat of a distinction.*
>
> NRF is joined in this coalition not only by traditional allies like the American Benefits Council, Aetna, the U.S. Chamber of Commerce and the National Association of Manufacturers (among others) *but also by the National Alliance on Mental Illness, the American Psychiatric and the American Psychological Associations and the American Hospital Association and the Federation of American Hospitals (among others).* I have attached a copy of our joint letter at the conclusion of my testimony. I respectfully ask that it be made part of the hearing record.[6]

[6] Testimony of E. Neil Trautwein, testifying on behalf of the National Retail Federation, Committee on Education and Labor, Subcommittee on Health, Education, Labor, and Pensions Hearing, "The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)," (July 10, 2007) at 3–4 (emphasis added).

Mr. Breyfogle, an employment benefits practitioner with decades of experience, explained to the Subcommittee the reasons underlying support for the Senate bill, and specific concerns with the House bill. In particular, Mr. Breyfogle expressed concerns with H.R. 1424's ERISA preemption provisions. As Mr. Breyfogle testified:

> We have significant concerns with the provisions in the House parity bill which would authorize States to provide "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than the provisions set out in the legislation. *Clearly, this language gives States the ability to develop parity laws, at least for fully insured health plans, that are more extensive than the federal standards provided in the House bill.* We prefer the approach adopted in the Senate bill, which would establish uniform federal parity rules applicable to treatment limitations and financial requirements for both self-insured and insured plans while preserving the traditional authority of States to require fully insured plans to provide mental health coverage.
>
> *The more troubling aspect of this provision in the House bill is that it opens the door for greater State law remedies for disputes involving mental health benefits for participants in insured plans.* The Supreme Court has issued numerous rulings making clear that ERISA's enforcement scheme is exclusive for both fully insured and self-insured plans and completely preempts alternative State remedial schemes. It makes no sense whatsoever to allow access to State law remedies for one category of benefits—i.e., participants in fully insured plans for disputes over mental health benefits. To the extent the House bill is interpreted to revise remedies for all types of benefit disputes, H.R. 1424 is certainly not the vehicle to do so. The debate over ERISA's remedies has occurred over many years, generally in the context of the Patients' Bill of Rights. *Such a fundamental issue as ERISA's remedial scheme should not be an adjunct to a bill whose purpose is to address mental health parity.*
>
> *The uniformity that ERISA establishes for employer-sponsored coverage, including its enforcement and remedies scheme, is sound public policy and is something employers consider crucial to their voluntary decision to offer health coverage to their employees. If Congress believes that changes are needed in this area, such changes should be debated on their own merits rather than included as one of many provisions of a mental health parity bill.*[7]

Although testimony was received from other witnesses at the hearing in favor of mental health parity legislation, the main points raised by Mr. Trautwein and Mr. Breyfogle regarding the

[7] Testimony of Jon W. Breyfogle, Esq., testifying on behalf of the American Benefits Council, Committee on Education and Labor, Subcommittee on Health, Education, Labor, and Pensions Hearing, "The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)," (July 10, 2007) at 7 (emphasis added).

differences and impacts of the House and Senate bills remained largely unrebutted, or at best were the subject of legitimate disagreement among experts. Accordingly, credible testimony at the July 10, 2007 hearing established that H.R. 1424 did not accomplish mental health parity in a balanced and thoughtful manner, and that significant concerns remained regarding the imposition of mandated benefits. Notwithstanding (or possibly because of) these legitimate concerns, on July 12 the Democrat majority scheduled a full committee markup of H.R. 1424 for July 18, 2007. The Majority provided the final draft of the Chairman's Amendment to H.R. 1424 approximately twelve hours before the full committee markup.

Full Committee markup

On Wednesday, July 18, 2007, eight days after the Subcommittee hearing, the full Committee on Education and Labor met to consider and mark up H.R. 1424. An Amendment in the Nature of a Substitute to H.R. 1424 was offered by Chairman Miller (the "Miller Amendment") and was adopted without objection. A Substitute Amendment to the Miller Amendment was offered by Representative Kline which was rejected on a rollcall vote of 16 to 25. The Committee favorably reported H.R. 1424, as amended by the Miller Amendment, on a rollcall vote of 33 to 9.

Amendment in the Nature of a Substitute to H.R. 1424, offered by Mr. George Miller of California

At the full Committee markup, Chairman Miller offered an Amendment in the Nature of a Substitute to H.R. 1424 ("the Miller Amendment"). The Miller Amendment set forth minor revisions primarily to Section 2 of H.R. 1424. The late evening of July 17 was the first time that Minority Members and staff were afforded the opportunity to review legislative text purporting to address concerns associated with H.R. 1424.

Among its provisions, the Miller Amendment adds "emergency care" to the categories of items and services for application of treatment limits and beneficiary financial requirements. In an apparent attempt to address testimony received at the July 10 Subcommittee hearing, the Miller Amendment includes a new provision regarding medical management which provides that nothing in the bill shall limit a group health plan from managing, using certain methods, the provision of medical, surgical, mental health or substance-related disorder benefits, to the extent the methods are recognized and not prohibited under state laws. The Amendment makes modest revisions to the notice requirements under the cost exemption section.

The Miller Amendment appears to seek to clarify the bill's preemption section relating to state laws, ostensibly to address concerns raised regarding the impact of H.R. 1424's broad provision permitting state laws to supersede the federal ERISA law. Specifically, section 2(i) of the Miller Amendment provides that the bill shall not be construed to supersede "any provision of State law which establishes, implements, or continues in effect any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance

issuers in connection with group health insurance coverage (including benefit mandates or regulation of group health plans of 50 or fewer employees) except to the extent that such provision prevents the application of a requirement of this part." It is further stated that nothing in the section would affect or modify the provision of ERISA Section 514 with respect to group health plans.

The Miller Amendment adds a special rule for collective bargaining agreements that would generally preclude application of the bill's requirements until after expiration of the agreement or January 1, 2010, whichever is later. It adds a requirement on the Department of Labor to randomly sample group health plan compliance with the parity bill's requirements, and to provide "assistance" to participants and beneficiaries who have any questions or problems with compliance with the bill's requirements. Finally, in a revision to section 5 of H.R. 1424, the Miller Amendment directs the Department of Labor, rather than the Comptroller General, to prepare biannual reports to Congress on access to coverage.

The Miller Amendment attempts to address some of the significant concerns raised with H.R. 1424. Despite good intent, however, the original bill remains largely unchanged, and the Miller Amendment does not provide sufficient clarity necessary to resolve some of the most troubling substantive concerns with the House legislation.

Kline Substitute Amendment

As discussed above, over the last two years significant progress on the issue of mental health parity has been made through the efforts of a bipartisan group of Senators (Kennedy, Enzi, and Domenici, among others) and a diverse and representative group of mental health advocates, health care providers, business groups and insurers. The unprecedented agreement reached among this bipartisan group is reflected in S. 558, with subsequent minor changes contained in the proposed manager's amendment to that bill.

In order to support the good policy and balanced compromise between all parties interested in achieving true mental health parity, which is and should be the goal of any legislation, Mr. Kline offered a substitute amendment at the full committee markup of H.R. 1424 (the "Kline Substitute"). The Kline Substitute embodies the proposed manager's amendment to S. 558.

The Kline Substitute addresses many of the concerns raised by the House bill. The Kline Substitute does not mandate that health plans cover specific mental health benefits, makes clear that medical management of mental health benefits and core payment and contracting issues necessary for success are not prohibited, and does not mandate costly out-of-network coverage. Further, the Kline Substitute ensures that ERISA preemption requirements are maintained and strengthened, in order to assure a uniform federal rule for the comprehensive and strong parity benefits provided by the bill. As such, it provides broad new parity requirements to participants in insured plans in approximately eight states that currently have no parity requirement and expands upon the parity requirements applicable to insured plans in approximately seventeen other states. It does this while ensuring that states can continue

their tradition role of regulating benefits provided under insurance policies in all other respects.

It is important to note that, regardless of whether they support or oppose H.R. 1424, all of the parties involved in the Senate negotiations strongly support enactment of the manager's amendment of S. 558 into law this year.

The Kline Substitute was rejected on a rollcall vote of 16 to 25, with every Democrat present voting against it. The Democrats' rejection of a broad-based and well-balanced substitute, which is publicly supported by mainstream mental health advocates and providers, threatens to undo the careful balance struck among all parties interested in this issue, and will make passage of meaningful mental health parity legislation this year exceedingly difficult.

REPUBLICAN VIEWS

Committee Republicans are united in their desire to achieve parity between mental health and other medical benefits. However, the significant differences in current legislative efforts, as discussed herein, may only serve to frustrate this goal.

Notwithstanding the rhetoric from supporters of H.R. 1424 and the Miller Amendment (hereafter collectively, unless specified otherwise, "H.R. 1424") which purports to characterize that legislation as providing "parity," H.R. 1424 does nothing of the sort. In fact, largely because of the defined benefit and preemption provisions, H.R. 1424 would create a situation in which employer-sponsored plans would likely have to provide significantly greater mental and behavioral health benefits as compared to other medical benefits. This, for example, raises a question of fundamental fairness, left unanswered by the Majority: Why should those who potentially suffer from mental and behavioral illnesses be entitled to greater employer-sponsored benefits than an individual suffering from another medical condition, such as cancer?

As set forth below, H.R. 1424's flaws are numerous. As such, it should be rejected by the House.

H.R. 1424 imposes a benefit mandate that defines covered illnesses too broadly

Under H.R. 1424, every mental illness identified by the mental health profession through the DSM–IV would be required to be covered by health plans. Even the vast majority of states currently do not mandate this type of coverage. Further, H.R. 1424 applies no similar requirement on any other category of medical benefits covered by a plan (hospital services, physician services, drug benefits, or any other category of benefits), many of which involve serious medical conditions. At the same time, an employer is obligated to provide coverage for disorders such as "caffeine intoxication" and "jet lag," which raises serious questions about the validity of the conditions to be covered by this bill. The Majority apparently believes that "caffeine intoxication" and "jet lag" are the types of disorders that are worthy of a federal coverage mandate on employer-sponsored plans.

Beyond the questionable nature of some of the "disorders" that would be required to be covered, H.R. 1424 does not create parity between medical/surgical and mental health conditions which must

be covered by a plan. Rather, at bottom, it is a preferential benefit mandate in favor of mental health conditions, which would override many existing state mandates for insurance plans that require coverage of a specific list of behavioral health and substance abuse conditions.

The Majority may argue that beneficiaries in private, employer-sponsored plans should be entitled coverage for the same illnesses covered by the FEHBP. However, this argument is misleading. Simply because the federal government, through an executive order issued by then-President Clinton, chose to provide such coverage does not mean all employer-sponsored plans should be mandated by the federal government to do the same. Employers, like the federal government, are in the best position to assess the needs of their covered populations, and should be permitted to exercise their discretion to voluntarily assume which illnesses they choose to cover. It was for that reason that the Kline Substitute preserved the ability of group plans to use their discretion in determining covered benefits, and preserved the ability of states to mandate benefits only in certain circumstances.

H.R. 1424 significantly weakens ERISA preemption

Under the House bill as introduced, states would be authorized to enact "greater consumer protections, benefits, methods of access to benefits, rights or remedies" than the provisions set out in the legislation. This would give states the ability to develop parity laws, at least for fully insured health plans, that are more extensive than the federal standards provided in the House bill. A further concern is that virtually limitless state law remedies could be available to participants in insured plans for disputes involving mental health benefits.

The Miller Amendment appears to attempt to correct these flaws by inserting new language relating to ERISA preemption, and its relation to state laws. The Majority may attempt to argue that this new language is consistent with provisions of the Health Insurance Portability and Accountability Act that have been in effect for many years. However, a close reading of the language reveals the potential for a substantial weakening of ERISA preemption. For example, the new language fails to clarify Congressional intent with sufficient specificity, as set forth in the Kline Substitute, that if any provision of a state law is preempted, any remaining provision of such law shall remain in effect and not be preempted. In addition, the claim by the Majority that the new language provides no new litigation rights for participants is questionable at best, if not simply incorrect. The new language specifically provides that any provision of state law that establishes, implements or continues "any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies" is not superseded. Although the new language limits the provision to group health insurance, and ostensibly continues ERISA preemption with respect to group health plans, this point will undoubtedly be the subject of litigation, and raises the substantial possibility of a significant erosion of ERISA preemption developed by court precedent over more than 30 years, Accordingly, the Miller Amendment creates the po-

tential for confusing and conflicting state laws, and makes employer-sponsored plans subject to increased costs.

If the Majority is truly interested in preserving ERISA preemption and not creating more expansive rights and remedies only for mental health benefits, as they stated at the full Committee mark-up, they simply would have sought to adopt the preemption language of the Kline Substitute, which is acceptable to interested stakeholders on both sides of this debate.[8] The failure to do so suggests that the Majority is more interested in expanding rights and remedies and fueling litigation for a specific and narrow class of benefits.

H.R. 1424 does not adequately address medical management of claims

Apparently in response to testimony received from Republican witnesses at the Subcommittee hearing, H.R. 1424 as reported contains specific language which appears to attempt to authorize the use of medical management practices for mental health benefits. However, it still omits a key component that helps improve the effectiveness of medical management practices, which is contained in the Kline Substitute.

Specifically, H.R. 1424 does not make clear that under its provisions group health plans are not prohibited from negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits. This provision, combined with the specific authorization of medical management practices, would serve to provide group health plans with the tools necessary to appropriately manage and deliver mental and behavioral health care benefits. Further, given that such contracting practices are in use in the FEHBP, the Majority's failure to include this specific authorization is inexplicable. As such, H.R. 1424 fails to protect the core payment and contracting practices that are essential to successful medical management programs that control cost and quality of benefits, and is therefore deficient.

H.R. 1424 mandates out-of-network coverage

H.R. 1424 mandates out-of-network coverage if a plan provides coverage for substantially all medical and surgical services in either emergency, inpatient or outpatient services. This is not "parity," since it limits the ability of employer-sponsored plans to design benefit programs. Also, it exceeds the FEHBP requirement to provide parity only for in-network services. Although the Majority references the FEHBP program as the standard by which private plans should operate, they selectively exclude those portions of the FEHBP program which do not further the Majority's goals. This provision should be rejected.

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[8] We note that there has been significant debate regarding the impact of S. 558 on ERISA preemption. See, Mila Kofman, Letter to Speaker Nancy Pelosi (June 15, 2007) and Sara Rosenbaum, JD, Letter to Senators Pete Domenici, Edward Kennedy and Michael Enzi (June 27, 2007). Negotiations over this particular provision continue, and will hopefully be resolved to the satisfaction of all stakeholders.

Employer mandates will increase costs and decrease coverage

There is no debate over whether H.R. 1424 will increase the costs of employer-sponsored group health plan premiums. It will, and testimony from the Majority's own witnesses confirm this fact. The only question involves how much will premium costs increase as a result of this mandate. At the Subcommittee hearing, the Majority cited testimony from an allegedly independent analysis of H.R. 1424 that found a premium cost increase of approximately 0.6 percent for "typical" plans, and 0.1 percent if medical management practices are adopted. However, this analysis was not prepared by CBO, and can by no means be considered "independent" in that it was prepared by a paid actuarial consultant for several behavioral health organizations interested in passage of H.R. 1424. Also, the Miller Amendment fails to fully authorize medical management practices. Further, even under this analysis many group health plans, especially smaller plans, may experience cost increases significantly above the increase for a "typical" plan.

Although there can be legitimate debate over the extent of cost increases, there should be no debate that imposing mandates increases costs and likely decreases the affordability and quality of coverage provided. Although when viewed in isolation, coverage mandates may appear to be more economically feasible and desirable, we remain concerned that the Majority will continue to consider the future imposition of additional coverage mandates. The cumulative costs associated with these mandates will have a detrimental impact on the quality and affordability of health care benefits. This appears to be contrary to the shared goal of all Members to expand access to affordable, high quality coverage.

CONCLUSION

As we noted at the outset, the goal of providing parity between mental health benefits and other medical benefits provided under employer-sponsored health coverage is something that all Members of the Committee, and many in Congress, would likely endorse. There have been significant advances in diagnosis and treatment of mental and behavioral health disorders, and Committee Republicans generally believe that mental health benefits should be provided on the same terms as medical and surgical benefits. We recognize the two current legislative proposals, H.R. 1424 and S. 558, offer substantially different approaches toward achieving parity.

However, only one bill, S. 558, before this Committee as the Kline Substitute at markup, achieves true parity and represents the product of two years of negotiation and agreement among a diverse group of interested stakeholder in this debate. The authors of H.R. 1424 did not involve all interested stakeholders, and the legislation appears to place mental health benefits in a more favored posture than all other medical benefits. Further, although attempts were made at full Committee markup to improve the bill, despite these efforts, it remains fundamentally flawed. If passed by the House, H.R. 1424, which differs substantially with legislation that could pass the Senate, will only serve to complicate enactment of mental health parity legislation this year.

For all of the reasons stated above, we oppose the passage of H.R. 1424.

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