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PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

OCTOBER 15, 2007.—Ordered to be printed

Mr. RANGEL, from the Committee on Ways and Means, 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 Ways and Means, 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. 4. 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 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 under 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 (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 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.—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)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).".

(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) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.".

(i) 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.".

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

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 finan-

cial 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.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

"(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 or 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 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.

"(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.

"(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.

"(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.

"(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 or substance-related disorders).

"(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.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

"(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 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 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 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 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 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, 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.—Section 9812 of such Code is further amended—

(1) by striking "mental health benefits" each place it appears (other than in any provision amended by paragraph (2)) and inserting "mental health or substance-related disorder benefits",

(2) by striking "mental health benefits" each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting "mental health and substance-related disorder benefits", and

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

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

"(5) SUBSTANCE-RELATED DISORDER BENEFITS.—The term 'substance-related disorder benefits' means benefits with respect to services for substance-related disorders, as defined under the terms of the plan.".

(c) AVAILABILITY OF PLAN INFORMATION ABOUT CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of section 9812 of such Code, 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 section 9812 of such Code 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 that provides any mental health or substance-related disorder benefits, the plan shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

"(i) IN GENERAL.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause (ii) furnished outside any network of providers established or recognized under such plan, 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 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) REVISION OF INCREASED COST EXEMPTION.—Paragraph (2) of section 9812(c) of such Code 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 to which this paragraph applies, 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 and licensed 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.—Paragraph (1) of section 9812(c) of such Code 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.—Section 9812 of such Code is amended by striking subsection (f).

(h) CONFORMING AMENDMENTS TO HEADING.—

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

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

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code 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.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2008.

(2) ELIMINATION OF SUNSET.—The amendment made by subsection (g) shall apply to benefits for services furnished after December 31, 2007.

(3) 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 (other than subsection (g)) 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.

SEC. 5. GOVERNMENT ACCOUNTABILITY OFFICE STUDIES AND REPORTS.

(a) IMPLEMENTATION OF ACT.—

(1) 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) BIANNUAL REPORT ON OBSTACLES IN OBTAINING COVERAGE.—Every two years, the Comptroller General shall submit to 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.

(c) UNIFORM PATIENT PLACEMENT CRITERIA.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to 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 critiera. If such criteria do not exist, the report shall include recommendations on a process for developing such criteria.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

PURPOSE

The bill modifies the mental health parity requirements under the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and the Internal Revenue Code and expands such requirements to substance-related disorder benefits. The requirements under the bill will result in true parity in the way that physical and mental health benefits are provided under group health plans. The provisions of the bill are necessary to end the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits.

SUMMARY

The provisions of the bill, H.R. 1424, as adopted by the Subcommittee, are as follows:

• Section 4 modifies the mental health parity requirements under the Internal Revenue Code and applies such requirements to substance-related disorder benefits. Section 4 expands the present law parity requirements to treatment limits and beneficiary financial requirements. Section 4 also provides minimum benefits that must be provided in the case of a plan that offers mental health or substance-related disorder benefits. Section 4 also eliminates the sunset under present law, making the parity requirements for mental health and substance-related disorders permanent.

B. BACKGROUND AND NEED FOR LEGISLATION

Many group health plans are discriminatory with respect to the benefits provided for mental health and substance-related disorder benefits. Many plans offer better treatment benefits for physical health conditions than for mental health conditions. Because of this discriminatory treatment, many individuals with mental illness or chemical dependency are unable to receive treatment for their conditions.

C. LEGISLATIVE HISTORY

Background

H.R. 1424 was introduced in the House of Representatives on March 8, 2007, and was referred to the Committee on Education and Labor, the Committee on Energy and Commerce, and the Committee on Ways and Means for a period to be determined by the Speaker of the House, in each case for consideration of such provisions as fall within the jurisdiction of the Committee concerned. The bill, as amended, was ordered to be reported by the Committee on Education and Labor on July 18, 2007.

Subcommittee hearings

The Subcommittee on Health of the Committee on Ways and Means conducted a hearing on the bill on March 27, 2007.

Subcommittee action

The Subcommittee on Health of the Committee on Ways and Means marked up the bill on September 19, 2007, and ordered the bill, as amended, favorably reported to the full Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up the bill on September 26, 2007, and ordered the bill, as amended, favorably reported.

II. EXPLANATION OF THE BILL

A. EXPANSION OF MENTAL HEALTH PARITY REQUIREMENTS (SEC. 9812 OF THE CODE)

PRESENT LAW

The Code, the Employee Retirement Income Security Act of 1974 ("ERISA") and the Public Health Service Act ("PHSA") contain provisions under which group health plans that provide both medical and surgical benefits and mental health benefits cannot impose aggregate lifetime or annual dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits ("mental health parity requirements"). In the case of a group health plan which provides benefits for mental health, the mental health parity requirements do not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan, except as specifically provided in regard to parity in the imposition of aggregate lifetime limits and annual limits.

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

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

The mental health parity requirements do not apply to group health plans of small employers. A small employer generally includes an employer who employs at least two, but no more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.[1] The mental parity requirements also do not apply if their application results in an increase in the cost under a group health plan of at least one percent. Further, the mental health parity requirements do not require group health plans to provide mental health benefits.

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

REASONS FOR CHANGE

Employers and insurance companies routinely discriminate against persons struggling with mental illness and addiction by denying coverage for mental health and substance abuse treatments. In addition, insurers often increase patients' costs for mental health treatment by limiting inpatient days, capping outpatient visits, and requiring higher co-payments than for physical illnesses. It is estimated that over 90 percent of workers with employer-sponsored health insurance are enrolled in plans that impose higher costs in at least one of these ways. Furthermore, 48 percent are enrolled in plans that impose all three Limitations.[2] These unfair treatment limitations are a major barrier to receiving care. Many individuals cannot afford to pay out-of-pocket for such treatment which results in many mental health and substance-related disorder conditions going untreated.

The Committee believes that the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits must be prohibited. Diseases of the mind should be afforded the same treatment as diseases of the body. The bill will end this discrimination by prohibiting health insurers from placing discriminatory restrictions on treatment and cost sharing. Extending these requirements to out-of-network services is necessary to achieve true parity. If a plan covers out-of-network services for physical health, it should also provide out-of-network services for mental health. Furthermore, restricting access to services provided "in-network" seriously limits treatment options and availability of appropriate providers.

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

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

The Committee believes that in the case of a plan that provides mental health or substance-related disorder benefits, certain minimum benefits must be provided. Recognizing the Diagnostic and Statistical Manual (DSM) as the minimum benefit standard ensures appropriate, scientifically-based coverage of these conditions. The DSM was developed by more than 1,000 national and international health care researchers and clinicians drawn from a wide range of mental and general health fields and is widely acknowledged as the empirical guide for diagnosing mental health disorders. Without this standard, plans could continue the practice of using arbitrary, non-scientific criteria in determining what mental illnesses and addictive disorders they cover.

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

Finally, the Committee believes that the parity requirements should be permanent to provide certainty as to the applicable requirements.

EXPLANATION OF PROVISION

In general

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

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

Treatment limits and beneficiary financial requirements

Treatment limits

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

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

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

such category that is more restrictive than the predominant [4] treatment limit that is applicable to medical and surgical benefits for items and services within such category.

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

1. Inpatient, in-network—Items and services, not described in (5) below, furnished on an inpatient basis and within a network of providers established or recognized under such plan.

2. Inpatient, out-of-network—Items and services, not described in (5) below, furnished on an inpatient basis and outside any network of providers established or recognized under such plan.

3. Outpatient, in-network—Items and services, not described in (5) below, furnished on an outpatient basis and within a network of providers established or recognized under such plan.

4. Outpatient, out-of-network—Items and services, not described in (5) below, furnished on an outpatient basis and outside any network of providers established or recognized under such plan.

5. Emergency care—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (including an emergency medical condition relating to mental health or substance-related disorders).

Beneficiary financial requirements

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

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

If a plan includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan must apply such requirements [5] both to medical and surgical benefits within such category and mental health and substance-related disorder benefits within such category and may not distinguish in the application of such requirement between

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

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

such medical and surgical benefits and such mental health and substance-related disorder benefits.

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

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

Availability of plan information regarding criteria for medical necessity

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

Minimum benefit requirements

The provision provides rules for the minimum benefits that must be provided in the case of a plan that provides mental health and substance-related disorder benefits. Under the provision, in the case of a group health plan that provides any mental health or substance-related disorder benefits, the plan must include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (currently DSM–IV).

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

1. Emergency—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (including an emergency condition relating to mental health or substance-related disorders).

2. Inpatient—Items and services not described in (1) furnished on an inpatient basis.

3. Outpatient—Items and services not described in (1) furnished on an outpatient basis.

Increased cost exception

The provision modifies the increased cost exemption under present law. Under the provision, if the application of the mental health and substance-related disorder parity requirements results in an increase for the plan year involved of the actual total costs of coverage [6] by an amount that exceeds one percent (two percent in the case of the first plan year to which the provision applies) of the actual total plan costs, such requirements do not apply to the plan during the following plan year. This exception applies to the plan for one plan year. If a plan seeks use of the exemption, the determination whether the exemption applies must be made after the plan has complied with the rules for the first six months of the plan year involved.

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

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

Small employer exception

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

Effective date

The provision is effective with respect to plan years beginning on or after January 1, 2008.

The elimination of the sunset of the present law mental health parity requirements is effective for benefits for services furnished after December 31, 2007.

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

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

solely to conform to any requirement imposed under the provision is not treated as a termination of such collective bargaining agreement.

III. VOTES OF THE COMMITTEE

A. Motion To Report the Bill

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

The bill, H.R. 1424, as amended, was ordered favorably reported by recorded vote of 27 yeas to 13 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel	X			Mr. McCrery		X	
Mr. Stark	X			Mr. Herger		X	
Mr. Levin	X			Mr. Camp		X	
Mr. McDermott	X			Mr. Ramstad	X		
Mr. Lewis (GA)	X			Mr. Johnson		X	
Mr. Neal	X			Mr. English	X		
Mr. McNulty	X			Mr. Weller	X		
Mr. Tanner	X			Mr. Hulshof		X	
Mr. Becerra	X			Mr. Lewis (KY)		X	
Mr. Doggett	X			Mr. Brady		X	
Mr. Pomeroy	X			Mr. Reynolds		X	
Ms. Tubbs Jones	X			Mr. Ryan		X	
Mr. Thompson	X			Mr. Cantor		X	
Mr. Larson	X			Mr. Linder		X	
Mr. Emanuel	X			Mr. Nunes		X	
Mr. Blumenauer	X			Mr. Tiberi		X	
Mr. Kind	X			Mr. Porter		X	
Mr. Pascrell	X						
Ms. Berkley	X						
Mr. Crowley	X						
Mr. Van Hollen	X						
Mr. Meek	X						
Ms. Schwartz	X						
Mr. Davis	X						

B. Votes on Amendments

A rollcall vote was conducted on the following amendments to the Chairman's amendment in the nature of a substitute.

An amendment by Mr. Hulshof, which would modify the minimum benefit standards under the bill, was defeated by a rollcall vote of 12 yeas to 26 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel		X		Mr. McCrery	X		
Mr. Stark		X		Mr. Herger	X		
Mr. Levin		X		Mr. Camp	X		
Mr. McDermott		X		Mr. Ramstad		X	
Mr. Lewis (GA)		X		Mr. Johnson	X		
Mr. Neal		X		Mr. English		X	
Mr. McNulty		X		Mr. Weller		X	
Mr. Tanner				Mr. Hulshof	X		
Mr. Becerra		X		Mr. Lewis (KY)	X		
Mr. Doggett		X		Mr. Brady	X		
Mr. Pomeroy		X		Mr. Reynolds	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Ms. Tubbs Jones		X		Mr. Ryan	X		
Mr. Thompson		X		Mr. Cantor	X		
Mr. Larson		X		Mr. Linder	X		
Mr. Emanuel		X		Mr. Nunes	X		
Mr. Blumenauer		X		Mr. Tiberi	X		
Mr. Kind		X		Mr. Porter	X		
Mr. Pascrell		X					
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis		X					

An amendment by Mr. Camp, which would modify certain provisions with respect to out-of-network coverage, was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel		X		Mr. McCrery	X		
Mr. Stark		X		Mr. Herger			
Mr. Levin		X		Mr. Camp	X		
Mr. McDermott		X		Mr. Ramstad		X	
Mr. Lewis (GA)		X		Mr. Johnson	X		
Mr. Neal		X		Mr. English	X		
Mr. McNulty		X		Mr. Weller	X		
Mr. Tanner		X		Mr. Hulshof	X		
Mr. Becerra		X		Mr. Lewis (KY)	X		
Mr. Doggett		X		Mr. Brady	X		
Mr. Pomeroy		X		Mr. Reynolds	X		
Ms. Tubbs Jones		X		Mr. Ryan	X		
Mr. Thompson		X		Mr. Cantor	X		
Mr. Larson		X		Mr. Linder	X		
Mr. Emanuel		X		Mr. Nunes	X		
Mr. Blumenauer		X		Mr. Tiberi	X		
Mr. Kind		X		Mr. Porter	X		
Mr. Pascrell		X					
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis		X					

An amendment by Mr. Hulshof, which would provide rules relating to medical management, was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel		X		Mr. McCrery	X		
Mr. Stark		X		Mr. Herger			
Mr. Levin		X		Mr. Camp	X		
Mr. McDermott		X		Mr. Ramstad		X	
Mr. Lewis (GA)		X		Mr. Johnson	X		
Mr. Neal		X		Mr. English	X		
Mr. McNulty		X		Mr. Weller	X		
Mr. Tanner		X		Mr. Hulshof	X		
Mr. Becerra		X		Mr. Lewis (KY)	X		
Mr. Doggett		X		Mr. Brady	X		
Mr. Pomeroy		X		Mr. Reynolds	X		
Ms. Tubbs Jones		X		Mr. Ryan	X		
Mr. Thompson		X		Mr. Cantor	X		
Mr. Larson		X		Mr. Linder	X		
Mr. Emanuel		X		Mr. Nunes	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Blumenauer		X		Mr. Tiberi	X		
Mr. Kind		X		Mr. Porter	X		
Mr. Pascrell		X					
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis		X					

An amendment by Mr. Lewis of Kentucky, which would modify the increased cost exemption, was defeated by a rollcall vote of 15 yeas to 25 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel		X		Mr. McCrery	X		
Mr. Stark		X		Mr. Herger			
Mr. Levin		X		Mr. Camp	X		
Mr. McDermott		X		Mr. Ramstad		X	
Mr. Lewis (GA)		X		Mr. Johnson	X		
Mr. Neal		X		Mr. English	X		
Mr. McNulty		X		Mr. Weller	X		
Mr. Tanner		X		Mr. Hulshof	X		
Mr. Becerra		X		Mr. Lewis (KY)	X		
Mr. Doggett		X		Mr. Brady	X		
Mr. Pomeroy		X		Mr. Reynolds	X		
Ms. Tubbs Jones		X		Mr. Ryan	X		
Mr. Thompson		X		Mr. Cantor	X		
Mr. Larson		X		Mr. Linder	X		
Mr. Emanuel		X		Mr. Nunes	X		
Mr. Blumenauer		X		Mr. Tiberi	X		
Mr. Kind		X		Mr. Porter	X		
Mr. Pascrell		X					
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis		X					

An amendment by Mr. Camp, which would substitute the language in the Chairman's amendment with language from S. 558, was defeated by a rollcall vote of 13 yeas to 26 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Rangel		X		Mr. McCrery	X		
Mr. Stark		X		Mr. Herger			
Mr. Levin		X		Mr. Camp	X		
Mr. McDermott		X		Mr. Ramstad		X	
Mr. Lewis (GA)		X		Mr. Johnson	X		
Mr. Neal		X		Mr. English		X	
Mr. McNulty		X		Mr. Weller		X	
Mr. Tanner		X		Mr. Hulshof	X		
Mr. Becerra		X		Mr. Lewis (KY)	X		
Mr. Doggett		X		Mr. Brady	X		
Mr. Pomeroy		X		Mr. Reynolds	X		
Ms. Tubbs Jones		X		Mr. Ryan	X		
Mr. Thompson		X		Mr. Cantor	X		
Mr. Larson		X		Mr. Linder	X		
Mr. Emanuel		X		Mr. Nunes	X		
Mr. Blumenauer		X		Mr. Tiberi	X		
Mr. Kind		X		Mr. Porter	X		
Mr. Pascrell		X					

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Ms. Berkley		X					
Mr. Crowley		X					
Mr. Van Hollen		X					
Mr. Meek		X					
Ms. Schwartz		X					
Mr. Davis		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

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

The effects of the bill on Federal budget receipts is presented in the cost estimate provided by the Congressional Budget Office (see below).

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

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.

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

Note: HI = Hospital Insurance (Part A of Medicare)

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, amend the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA) to require mental health benefits of plans that choose to offer such benefits to 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. It also would amend the Internal Revenue Code (IRC) to require that the mental health benefits of plans that choose to offer such benefits to include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association (APA). CBO assumed that those standards would not be materially different and would have a negligible budgetary effect. In addition, existing laws in some states 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 ex-

ample, 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. CBO 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.

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, because 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 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 estimates: 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. On September 7, 2007, CBO transmitted a cost estimate for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, as ordered reported by the House Committee on Education and Labor on July 18, 2007.

The Ways and Means Committee's version of H.R. 1424 differs from the previous version in that it would not include a mechanism for auditing group health plans or for providing assistance to beneficiaries of such plans. In addition, it would amend the IRC to require mental health benefits of plans that choose to offer such benefits to include benefits that are included in the most recent edition of the DSM of Mental Disorders published by the APA. Because this change would not be materially different from the requirement that such benefits be at least as generous as the FEHBP with the highest average enrollment as of the beginning of the most recent plan year, CBO estimated that this would have a negligible budgetary effect.

Both versions of H.R. 1424 differ from S. 558 in several ways. H.R. 1424 would: (1) require mental health benefits of plans that choose to offer such benefits to meet a minimum benefits requirement; (2) 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) make conforming modifications to the Internal Revenue Code; and (4) 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 under H.R. 1424 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 impact on 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: Keith J. Fontenot, Deputy Assistant Director for Health and Human Resources, Budget Analysis Division.

D. Macroeconomic Impact Analysis

In compliance with clause 3(h)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made by the

Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: The effects of the bill on economic activity are so small as to be incalculable within the context of a model of the aggregate economy.

E. PAY-GO RULE

In compliance with clause 10 of rule XXI of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 1424, as reported: The provisions of the bill affecting revenues have the following net effect on the deficit or surplus: (1) the bill would not increase the deficit or reduce the surplus in fiscal year 2007; (2) the bill would increase the deficit or reduce the surplus by $1.1 billion over the fiscal year 2008–2012 period; and (2) the bill would increase the deficit or reduce the surplus by $3.12 billion over the fiscal year 2008–2017 period.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it is appropriate and timely to enact the provisions included in the bill as reported.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. CONSTITUTIONAL AUTHORITY STATEMENT

With respect to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives (relating to Constitutional Authority), the Committee states that the Committee's action in reporting this bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises . . ."), and from the 16th Amendment to the Constitution.

D. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4). 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 would only 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 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 be about $1.3 billion in 2008, and would grow in later years. That amount would significantly exceed the threshold established by UMRA ($131 million in 2007, adjusted for inflation) in each of the years that the mandate would be in effect.

E. Applicability of House Rule XXI 5(b)

Clause 5 of rule XXI of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not involve any Federal income tax rate increases within the meaning of the rule.

F. Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Department of the Treasury) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

The staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Code and that have "widespread applicability" to individuals or small businesses.

G. Limited Tax Benefits

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, the Ways and Means Committee has determined

that the bill as reported contains no congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of that Rule.

VI. 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.

TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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

[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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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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[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 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 ben-

efits] *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, 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 under 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 (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 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 sur-

gical 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 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.

(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.—

(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 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.—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)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).

* * * * * * *

(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 services**]** *benefits with respect to services for mental health condi-*

tions 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) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

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PUBLIC HEALTH SERVICE ACT

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TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

PART A—GROUP MARKET REFORMS

* * * * * * *

Subpart 2—Other Requirements

* * * * * * *

[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 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.

(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 cer-

tified 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.

(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

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

(1) * * *

* * * * * * *

(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 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.—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.

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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. 9811. Standards relating to benefits for mothers and newborns.
[Sec. 9812. Parity in the application of certain limits to mental health benefits.]
Sec. 9812. Equity in mental health and substance-related disorder benefits.

* * * * * * *

[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 or 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 or 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 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 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 or 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 or 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 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 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.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

(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 or 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 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.

(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.

(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.

(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.

(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 or substance-related disorders).

(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.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

(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 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 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 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 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 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, 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 that provides any mental health or substance-related disorder benefits, the plan shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

(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 or 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 to which this paragraph applies, 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 and licensed 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.

* * * * * * *

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

[(4) MENTAL HEALTH BENEFITS.—The term "mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.]

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

(5) SUBSTANCE-RELATED DISORDER BENEFITS.—The term "substance-related disorder benefits" means benefits with respect to services for substance-related disorders, as defined under the terms of the plan.

[(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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VII. DISSENTING VIEWS

MINORITY VIEWS ON H.R. 1424, THE "PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007"

INTRODUCTION

Republican members of the Committee support providing parity between mental health benefits and other medical benefits provided under employer-sponsored health coverage. In the 110th Congress, the House and Senate are offering two different approaches in addressing this issue. The proposal advancing in the Senate achieves the goal of parity and also has the support of both the business and mental health communities. 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.

Mental health parity bills have been introduced in prior Congresses, but have not been enacted into law in part because of serious concerns associated with these proposals and the opposition to additional federal coverage mandates on employers. Employers continue to struggle to provide affordable, high-quality coverage to their employees. According to the Congressional Budget Office (CBO), the House bill "would result in higher premiums for employer-sponsored health benefits." CBO also notes that this bill will lead to reductions in the number of employers offering health insurance and could cause health plans to eliminate coverage for mental health benefits andlor substance benefits.

The current parity bills, H.R. 1424 in the House and S. 558 in the Senate, represent two different approaches to the issue of achieving mental health parity. H.R. 1424, as reported by the Committee, reflects prior legislative efforts and does not address the concerns raised by those parties who will be required to comply with the new mandates. In contrast, the Senate bill reflects a carefully negotiated consensus of all major stakeholders on all sides of the mental health parity debate.

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. On September 18, 2007 the Senate passed S. 558 by Unanimous Consent. The Senate bill was the product of negotiations between patient advocates, behavioral health providers, insurers, and business groups.

S. 558 requires health insurance plans that offer mental health coverage to provide that coverage on par with other physical illnesses. The Senate bill would not mandate that plans provide specific mental health benefits, but rather only require that plans still comply with state-specific benefit requirements where applicable. 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.

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, and $150 million in increased appropriations.

House legislation

H.R. 1424 attempts to achieve mental health parity by prohibiting group health plans from imposing treatment limits or financial requirements on mental health and substance-related disorder benefits, if those requirements and limitations are not similarly imposed on medical and surgical benefits under such plans. The bill would also require that where a plan covers any behavioral health disorder, it must cover all currently recognized conditions listed in the DSM–IV. This mandate would potentially require coverage for certain disorders, such as "caffeine intoxication" and "circadian rhythm sleep disorder (jet lag)," and eliminate a plan's flexibility to determine its 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. Given the number of states that have already taken action, this ambiguity raises concerns that other states may limit medical management. 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, H.R. 1424 would give states the authority to enact greater rights or remedies than those contained under current federal statute. 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 action and remedies to be established, which would apply to mental health benefits but not other medical benefits. Under current law, plans have operated under the rights and remedies set forth under ERISA for over three decades.

CBO scored H.R. 1424 and concluded that it would result in a 0.4 percent increase in employer-sponsored premiums. This bill will increase mandatory spending by $310 million and further reduce federal revenues by $1.1 billion. These amounts are not offset, and will raise a budget point of order if this bill is brought to the House floor. We believe that any mental health parity bill should be fully

paid for, and any offsets should be fully vetted through the Committee process.

LEGISLATIVE HEARING ON H.R. 1424

On March 27, 2007, the Committee on Ways and Means, Subcommittee on Health, held a legislative hearing on H.R. 1424. The hearing featured the testimony of Representatives Kennedy and Ramstad, along with mental health advocates, including Dr. Michael Quirk and Dr. Henry Harbin, who is a former director of the State of Maryland Mental Health Authority. The hearing focused on the specific provisions of the House bill, but also included discussion of the Senate proposal.

Dr. Quirk, who is the director of Behavioral Health Services at Group Health Cooperative, testified about specific concerns with the House bill. Other witnesses, including Mr. Breyfogle, testified that national mental health parity policy will work best if it allows carriers the flexibility to design coverage and services that will benefit both individual patients and whole populations of people with similar problems. He also said that federal legislation should allow carriers like Group Health the flexibility to make reasonable determinations of medical necessity in order to determine who will benefit from care. Dr. Quirk stressed the importance of medical management, citing this as the tool that allows providers to make appropriate clinical decisions about patients.

FULL COMMITTEE MARKUP

On Wednesday, September 26, 2007, the full Committee on Ways and Means met to consider and mark up H.R. 1424. The following amendments were voted on during mark up.

Hulshof Amendment:

Mr. Hulshof offered an amendment that struck the requirement that plans must cover all conditions specified in the DSM–IV. His amendment instead would allow health plans and state laws to determine what mental health benefits are covered. This amendment would have aligned the House version of the bill to that of the Senate. The amendment was defeated by a rollcall vote of 12–26.

Johnson Amendment:

Mr. Johnson offered an amendment that would have incorporated the Senate's effective date, moving it from January 1, 2008 to January 1st of the year following the date of enactment. The amendment was withdrawn.

Camp Amendment:

Mr. Camp offered an amendment that struck the language requiring plans to provide out-of-network mental health benefits if the plan also provides out-of-network medical and surgical benefits. This would have brought the bill in line with the Senate bill and current FEHBP requirements. The amendment was defeated by a rollcall vote with a final tally of 15–25.

Weller Amendment:

Mr. Weller offered an amendment that would change the title of the bill to add Mr. Ramstad's name. At Mr. Ramstad's request, Mr. Weller withdrew the amendment.

Hulshof #2 Amendment:

Mr. Hulshof's second amendment would have clarified health plans' ability to offer medical management of mental health benefits. The ability to effectively manage mental health benefits is essential to provide high quality care and appropriately manage costs. This amendment would bring the House bill in line with the Senate bill and current FEHBP coverage. The amendment was defeated by a rollcall vote of 15–25.

Lewis Amendment:

Mr. Lewis offered an amendment that would protect patients from substantial premium increases. The amendment would provide patients with the same protections that this bill provides to health plans. Under the amendment, the amount that beneficiary premiums increased could not exceed the cap on allowable cost increases for plans. The amendment was defeated by a rollcall vote of 15–25.

Camp #2 Amendment:

Finally, Mr. Camp offered an amendment that would strike Section 4 and replace it with language from the Senate bill. This amendment would essentially replace the House version of the bill with the Senate version. The amendment was defeated by a rollcall vote of 13–26.

REPUBLICAN VIEWS

H.R. 1424 would require group health plans to provide significantly greater mental health and substance abuse benefits, as compared to other medical benefits. This raises a question of fundamental fairness. Parity equalizes care between mental health and medical benefits, yet H.R. 1424 goes beyond parity by imposing federal mandates on coverage.

As set forth below, there are several concerns with provisions of H.R. 1424. 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 in the DSM–IV would be required to be covered by health plans. Current federal law generally does not apply any similar requirement that group health plans cover broad categories of medical benefits, such as hospital services, physician services, or drug benefits.

H.R. 1424 SIGNIFICANTLY WEAKENS ERISA PREEMPTION

Under H.R. 1424, states would be authorized to enact "greater consumer protections, benefits, and methods of access to benefits, rights or remedies" than the provisions set in the legislation. This change would create a new legal basis to allow states to take ac-

tions against ERISA plans. The Supreme Court has consistently concluded that states may not establish their own rights or remedies for enrollees under ERISA plans. Instead, federal rights and remedies exclusively apply to ERISA health plan participants and their benefits. If states can apply their own remedies to mental health benefits (but not other categories of benefits), ERISA health plan participants would have different rights and remedies depending on the type of benefits.

H.R. 1424 DOES NOT ADEQUATELY ADDRESS MEDICAL MANAGEMENT OF CLAIMS

H.R. 1424 does not make clear that 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. In fact, FEHBP uses these practices to control the cost and quality of their benefits.

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. 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, this bill ignores significant portions of the FEHBP program.

CONCLUSION

We agree that there have been significant advances in diagnosis and treatment of mental, behavioral and substance abuse disorders. We believe that mental health benefits should be provided on the same terms as medical and surgical benefits. We also recognize the two current legislative proposals, H.R. 1424 and S. 558, offer substantially different approaches toward achieving parity.

However, only the Senate bill achieves true parity and represents the product of two years of negotiation and agreement among a diverse group of interested stakeholders. Although attempts were made at the full Committee markup to improve the bill, H.R. 1424 continues to have significant concerns. For this reason, we oppose passage of H.R. 1424.

JIM MCCRERY.
WALLY HERGER.
DAVE CAMP.
SAM JOHNSON.
KENNY HULSHOF.
RON LEWIS.
KEVIN BRADY.
TOM REYNOLDS.
DEVIN NUNES.
JON PORTER.

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