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# PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

MARCH 4, 2008.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

# R E P O R T

together with

## DISSENTING VIEWS

[To accompany H.R. 1424]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, 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.

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## AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents
Sec. 2. Amendments to the Employee Retirement Income Security Act of 1974
Sec. 3. Amendments to the Public Health Service Act relating to the group market
Sec. 5. Amendments to the Internal Revenue Code of 1986
Sec. 5. Government Accountability Office studies and reports

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

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

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

"(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

"(v) EMERGENCY CARE.—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health and substance-related disorders).

"(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term 'treatment limit' means, with respect to a plan or coverage, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan or coverage.

"(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or financial requirement with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of limit or requirement with respect to such category of items and services.

"(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

"(B) BENEFICIARY FINANCIAL REQUIREMENT.—

"(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

"(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that 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 or substance-related disorder benefits" each place it appears; and

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

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

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

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

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

"(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available 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 or substance-related disorder benefits, the plan or coverage 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 (or health insurance coverage offered in connection with such 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 in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

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

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

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

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

(e) 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 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 (or coverage) 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 (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 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. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.".**

(j) 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 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.

(k) CONSTRUCTION REGARDING USE OF MEDICAL MANAGEMENT TOOLS.—Nothing in this Act shall be construed to prohibit a group health plan or health insurance issuer from using medical management tools as long as such management tools are based on valid medical evidence and are relevant to the patient whose medical treatment is under review.

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

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

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

"(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

"(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term 'treatment limit' means, with respect to a plan, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan.

"(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or financial requirement with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of limit or requirement with respect to such category of items and services.

"(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

"(B) BENEFICIARY FINANCIAL REQUIREMENT.—

"(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and

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

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

"(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term 'beneficiary financial requirement' includes, with respect to a plan, any deductible, coinsurance, co-payment, other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan, but does not include the application of any aggregate lifetime limit or annual limit."; and

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

furnished outside any network of providers established or recognized under such plan in accordance with the requirements of this section.

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

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

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

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

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

"(2) INCREASED COST EXEMPTION.—

"(A) IN GENERAL.—With respect to a group health plan, if the application of this section to such plan results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan during the following plan year, and such exemption shall apply to the plan for 1 plan year.

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

"(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; and

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

"(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan for purposes of this subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

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

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

"(1) SMALL EMPLOYER EXEMPTION.—

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

"(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term 'small employer' means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.".

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

(h) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

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

**SEC. 5. 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 criteria. If such criteria do not exist, the report shall include recommendations on a process for developing such criteria.

## PURPOSE AND SUMMARY

The purpose of H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007" is to have fairness and equity in the coverage of mental health and substance-related disorders vis-à-vis coverage for medical and surgical disorders. This bill expands the Mental Health Parity Act of 1996 (Public Law 104–204) by requiring group health plans that offer benefits for mental health and substance-related disorders to do so on similar terms as care for other medical and surgical diseases. The legislation ensures that plans do not charge higher copayments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than the plan has for medical and surgical benefits. After years of discriminatory practices in plan design, health plans will be required to offer parity in treatment of mental illness and medical illness or face penalties by the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service.

## BACKGROUND AND NEED FOR LEGISLATION

More than 50 million adults, at least 22 percent of the U.S. population, suffer from mental disorders or substance abuse disorders

on an annual basis.[1] In addition, 1 out of every 10 children or adolescents has a serious mental health problem, and another 10 percent have mild to moderate problems.[2]

The results of untreated mental illness and substance related disorders include, but are not limited to, emotionally and financially unstable families and children, higher costs for businesses, and more criminal activity. Mental disorders are the leading cause of disability for individuals ages 15 to 44 in the United States.[3] A study sponsored by the National Institute of Mental Health revealed that mental and addictive disorders cost more than $300 billion annually. This includes productivity losses of $150 billion, healthcare costs of $70 billion, and $80 billion from other costs such as criminal justice.[4] More specifically, mental illnesses cause direct business costs of at least $70 billion per year, mostly in the form of lost productivity.[5] For those who suffer from mental illness, "mental disorders are treatable * * * there is generally not just one but a range of treatments of proven efficacy."[6] Unfortunately, less than one-third of people with a mental disorder who seek help receive minimally adequate care.[7]

Despite the losses suffered in our society as a result of mental illness, national employer survey data indicate that mental health coverage is still not offered at a level comparable to coverage for other medical conditions.[8] Even after the passage of the 1996 Mental Health Parity Act and given parity laws in numerous States, the Government Accountability Office found that 87 percent of plans had more restrictive design features for mental health benefits than for medical and surgical benefits.[9] In addition, many employers had adopted newly restrictive mental health benefit design features such as limiting the number of covered outpatient office visits for mental illness specifically to offset the parity they were required to provide in aggregate and lifetime limits.[10] A former Surgeon General of the United States, Dr. David Satcher, found that health insurance plans have unevenly imposed higher cost controls for mental health services such as placing a 50 percent copayment on outpatient psychotherapy visits.[11] Such inequity results in not only the reduction of inappropriate use of services, but

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[1] Health Care Reform for Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council, produced in response to a request by the Senate Committee on Appropriations, American Journal of Psychiatry 150:10, October 1993. The World Health Organization. *The World Health Report 2004: Changing History;* Annex Table 3: Burden of disease in Disability-Adjusted-Life-Years (DALY) by cause, sex, and mortality stratum in WHO regions, estimates for 2002. Geneva (2004).

[2] American Psychological Association.

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

[4] The Numbers Count: Mental Disorders in America, NIH Publication No. 01–4584, dated 2006 available at *http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml.*

[5] Mental Health: A Report of the Surgeon General, 1999.

[6] U.S. Dept. of Health and Human Services, Mental Health: A Report of the Surgeon General 46, 179 (1999) [hereinafter SGRMH].

[7] Wang PS, et.al., 12-month use of mental health services in the United States: results from the National Comorbidity Survey Replication, Archives of General Psychiatry, June 2005.

[8] Congressional Research Service, Mental Health Parity: Federal and State Action and Economic Impact, Updated January 25, 2007.

[9] Government Accountability Office, Mental Health Parity Act, Despite New Federal Standards, Mental Health Benefits Remain Limited, GAO/HEHS–00–95, May 2000.

[10] Government Accountability Office, Mental Health Parity Act, Despite New Federal Standards, Mental Health Benefits Remain Limited, GAO/HEHS–00–95, May 2000.

[11] Mental Health: A Report of the Surgeon General, 1999.

also on the appropriate use of services. Overall, Surgeon General Satcher stated it is an "issue of fairness in coverage policy."[12] Similarly, a more recent study found that deductibles and outpatient cost-sharing for substance abuse were much higher for substance abuse than for general medical care in 2006.[13]

States began addressing inequities in mental health coverage in the 1970s. Currently, most all States have mandated some level of parity. State parity laws, however, will have limited effect because they do not cover self-insured plans.[14] H.R. 1424 seeks fairness in coverage of mental health and substance-related disorders. The bill aims to increase access to mental health treatment by prohibiting group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits) or treatment limitations (including limitations on the number of visits, days of coverage, or frequency of treatment) on mental health and substance-related benefits that are more restrictive than those restrictions applied to medical and surgical benefits. This legislation provides a cost-effective way of promoting increased access to mental health care. Such conclusions are supported by the implementation and studies of parity within the Federal Employee Health Benefits Program. Studies found that parity between medical and surgical benefits and mental health and substance-related disorders resulted in a significant decline in out-of-pocket spending indicating that parity protection resulted in improved insurance protection against financial risks.[15] Another study found, "[t]he more generous a state's mental health parity coverage, the greater the number of people in the population that receive mental health services" and suggests that addressing discrimination in private health insurance by legislating parity could reduce depression and its negative consequences.[16]

## HEARINGS

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

There were also hearings held by the two House Committees that received secondary referral of H.R. 1417. The Subcommittee on

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[12] Mental Health: A Report of the Surgeon General, 1999.

[13] Colleen L. Barry and Jody L. Sindelar, Equity In Private Insurance Coverage For Substance Abuse: A Perspective On Parity, October 23, 2007.

[14] Ramya Sundararaman, C. Stephen Redhead, Mental Health Parity: Federal and State Action and Economic Impact, October 19, 2007.

[15] Howard H. Goldman, et. al., Behavioral Health Insurance Parity for Federal Employees, The New England Journal of Medicine, 354:13, March 30, 2006.

[16] Government Accountability Office, Mental Health Parity Act, Despite New Federal Standards, Mental Health Benefits Remain Limited, GAO/HEHS–00–95, May 2000.

Health of the Ways and Means Committee held a hearing entitled "Mental Health and Substance Abuse Parity" on March 27, 2007. On July 10 2007, the Subcommittee on Health, Employment, Labor, and Pensions of the Committee on Education and Labor held a hearing entitled "The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)."

## COMMITTEE CONSIDERATION

On Wednesday, October 10, 2007, the Subcommittee on Health met in open markup session and favorably forwarded H.R. 1424, amended, to the full Committee for consideration, by a voice vote. On Tuesday, October 16, 2007, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 1424 favorably reported to the House, as amended by the Subcommittee, by a record vote of 32 yeas and 13 nays. No amendments were approved during full Committee consideration.

## COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were six amendments offered during full Committee consideration that were defeated by a recorded vote. A motion by Mr. Dingell to order H.R. 1424 favorably reported to the House, as amended by the Subcommittee on Health, was agreed to by a record vote of 32 yeas and 13 nays. The following are the recorded votes taken on the amendments and the Dingell motion, including the names of those Members voting for and against:

**COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS**
**ROLL CALL VOTE # 36**[1]

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007

**MOTION:** An amendment to H.R. 1424, as amended, by Mrs. Wilson, No. 1, providing a substitute text for Section 3.

**DISPOSITION: DEFEATED,** by a roll call vote of 20 yeas to 33 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | X | | |
| Mr. Waxman | | X | | Mr. Hall | X | | |
| Mr. Markey | | X | | Mr. Hastert | X | | |
| Mr. Boucher | | | | Mr. Upton | X | | |
| Mr. Towns | | X | | Mr. Stearns | X | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | X | | Mr. Whitfield | X | | |
| Mr. Rush | | X | | Mrs. Cubin | | | |
| Ms. Eshoo | | X | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | X | | Mr. Shadegg | X | | |
| Mr. Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | X | | |
| Ms. DeGette | | X | | Mr. Buyer | X | | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | | X | |
| Mr. Allen | | X | | Mr. Walden | X | | |
| Ms. Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | X | | |
| Mr. Inslee | | X | | Mrs. Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | X | |
| Mr. Ross | | X | | Mr. Murphy | | X | |
| Ms. Hooley | | X | | Mr. Burgess | X | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | X | | | | | |
| Mr. Butterfield | | X | | | | | |
| Mr. Melancon | | X | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | X | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H.R. 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007. Roll call votes no. 35 through no. 42 actually occurred after the Committee's roll call vote no. 29 (July 27, 2007), and should have been numbered on the list as votes no. 30 through no. 37.

## COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS
## ROLL CALL VOTE # 37[1]

**BILL:** H.R 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007.

**MOTION:** An amendment to H.R. 1424, as amended, by Mr. Deal, No. 2, adding a new section providing that compliance with requirements and guidelines under FEHBP for mental health parity as in effect prior to the date of the bill's enactment will be deemed to satisfy the requirements of the bill.

**DISPOSITION: DEFEATED**, by a roll call vote of 14 yeas to 26 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | | | |
| Mr. Waxman | | X | | Mr. Hall | X | | |
| Mr. Markey | | | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | | | |
| Mr. Towns | | X | | Mr. Stearns | X | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | | | Mr. Whitfield | | | |
| Mr. Rush | | X | | Mrs. Cubin | | | |
| Ms. Eshoo | | | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | X | | Mr. Shadegg | X | | |
| Mr. Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | X | | |
| Ms. DeGette | | X | | Mr. Buyer | X | | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | | | |
| Mr. Allen | | | | Mr. Walden | X | | |
| Ms Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | | | |
| Mr. Inslee | | X | | Mrs. Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | X | |
| Mr. Ross | | X | | Mr. Murphy | | X | |
| Ms. Hooley | | X | | Mr. Burgess | | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | X | | | | | |
| Mr. Butterfield | | | | | | | |
| Mr. Melancon | | | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | X | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H R 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007. Roll call votes no. 35 through no 42 actually occurred after the Committee's roll call vote no 29 (July 27, 2007), and should have been numbered on the list as votes no 30 through no 37

**COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS**
**ROLL CALL VOTE # 38[1]**

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007.

**MOTION:** An amendment to H.R. 1424, as amended, by Mr. Deal, No. 4, revising the existing cost exemption to only be available for a 2 percent cost increase for the first plan year.

**DISPOSITION: DEFEATED**, by a roll call vote of 14 yeas to 29 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | | | |
| Mr. Waxman | | X | | Mr. Hall | X | | |
| Mr. Markey | | | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | | | |
| Mr. Towns | | X | | Mr. Stearns | X | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | X | | Mr. Whitfield | | | |
| Mr. Rush | | X | | Mrs. Cubin | | | |
| Ms. Eshoo | | | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | X | | Mr. Shadegg | X | | |
| Mr. Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | X | | |
| Ms DeGette | | X | | Mr. Buyer | X | | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | | | |
| Mr. Allen | | | | Mr. Walden | X | | |
| Ms. Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | | | |
| Mr. Inslee | | X | | Mrs Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | X | |
| Mr. Ross | | X | | Mr. Murphy | | X | |
| Ms. Hooley | | X | | Mr. Burgess | | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | X | | | | | |
| Mr. Butterfield | | X | | | | | |
| Mr. Melancon | | X | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | X | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H.R. 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007 Roll call votes no. 35 through no 42 actually occurred after the Committee's roll call vote no. 29 (July 27, 2007), and should have been numbered on the list as votes no. 30 through no 37

## COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS
## ROLL CALL VOTE # 39[1]

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2008.

**MOTION:** An amendment to H.R. 1424, as amended, by Mr. Rogers, No. 5, to insert an exception that ensures nothing restricts plans from denying a claim of an individual who has been convicted of child abuse or criminal activity and whose claim is based on such abuse or criminal activity.

**DISPOSITION: DEFEATED**, by a roll call vote of 16 yeas to 23 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | X | | |
| Mr. Waxman | | X | | Mr. Hall | X | | |
| Mr. Markey | | | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | X | | |
| Mr. Towns | | X | | Mr. Stearns | | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | | | Mr. Whitfield | X | | |
| Mr. Rush | | | | Mrs. Cubin | | | |
| Ms. Eshoo | | X | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | | | Mr. Shadegg | X | | |
| Mr. Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | | | |
| Ms. DeGette | | X | | Mr. Buyer | X | | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | | | |
| Mr. Allen | | | | Mr. Walden | | | |
| Ms. Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | X | | |
| Mr. Inslee | | X | | Mrs. Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | | |
| Mr Ross | | X | | Mr. Murphy | | | |
| Ms. Hooley | | X | | Mr. Burgess | X | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | | | | | | |
| Mr. Butterfield | | | | | | | |
| Mr. Melancon | | X | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | X | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H R 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007. Roll call votes no. 35 through no. 42 actually occurred after the Committee's roll call vote no 29 (July 27, 2007), and should have been numbered on the list as votes no. 30 through no 37.

**COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS**
**ROLL CALL VOTE # 40**[1]

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007.

**MOTION:** An amendment to H.R. 1424, as amended, by Mr. Burgess, No. 6, on page 25, line 20, strike "condition" and insert "disorder".

**DISPOSITION: DEFEATED**, by a roll call vote of 18 yeas to 28 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | X | | |
| Mr. Waxman | | X | | Mr. Hall | | | |
| Mr. Markey | | X | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | X | | |
| Mr. Towns | | X | | Mr. Stearns | X | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | X | | Mr. Whitfield | X | | |
| Mr. Rush | | | | Mrs. Cubin | | | |
| Ms. Eshoo | | X | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | | | Mr. Shadegg | X | | |
| Mr Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | | | |
| Ms. DeGette | | X | | Mr. Buyer | X | | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | X | | |
| Mr. Allen | | X | | Mr. Walden | | | |
| Ms. Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | X | | |
| Mr. Inslee | | X | | Mrs. Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | | |
| Mr. Ross | | X | | Mr. Murphy | X | | |
| Ms. Hooley | | X | | Mr. Burgess | X | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | X | | | | | |
| Mr. Butterfield | | X | | | | | |
| Mr. Melancon | | X | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | X | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H.R. 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007. Roll call votes no. 35 through no. 42 actually occurred after the Committee's roll call vote no. 29 (July 27, 2007), and should have been numbered on the list as votes no. 30 through no. 37

## COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS
## ROLL CALL VOTE # 41[1]

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007.

**MOTION:** An amendment to H.R. 1424, as amended, by Mr. Deal, No. 8, to require an examination of the selection process for the conditions and disorders in the DSM by the Secretary of Health and Human Services.

**DISPOSITION: DEFEATED**, by a roll call vote of 16 yeas to 31 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | | X | | Mr. Barton | X | | |
| Mr. Waxman | | X | | Mr. Hall | | | |
| Mr. Markey | | X | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | X | | |
| Mr. Towns | | X | | Mr. Stearns | X | | |
| Mr. Pallone | | X | | Mr. Deal | X | | |
| Mr. Gordon | | X | | Mr. Whitfield | X | | |
| Mr. Rush | | X | | Mrs. Cubin | | | |
| Ms. Eshoo | | X | | Mr. Shimkus | X | | |
| Mr. Stupak | | X | | Mrs. Wilson | X | | |
| Mr. Engel | | X | | Mr. Shadegg | | | |
| Mr Wynn | | X | | Mr. Pickering | X | | |
| Mr. Green | | X | | Mr. Fossella | X | | |
| Ms. DeGette | | X | | Mr. Buyer | | X | |
| Ms. Capps | | X | | Mr. Radanovich | X | | |
| Mr. Doyle | | X | | Mr. Pitts | X | | |
| Ms. Harman | | X | | Ms. Bono | X | | |
| Mr. Allen | | X | | Mr. Walden | | | |
| Ms. Schakowsky | | X | | Mr. Terry | X | | |
| Ms. Solis | | X | | Mr. Ferguson | | | |
| Mr. Gonzalez | | X | | Mr. Rogers | X | | |
| Mr. Inslee | | X | | Mrs. Myrick | | | |
| Ms. Baldwin | | X | | Mr. Sullivan | | | |
| Mr. Ross | | X | | Mr. Murphy | | X | |
| Ms. Hooley | | X | | Mr. Burgess | X | | |
| Mr. Weiner | | X | | Ms. Blackburn | X | | |
| Mr. Matheson | | X | | | | | |
| Mr. Butterfield | | X | | | | | |
| Mr. Melancon | | X | | | | | |
| Mr. Barrow | | X | | | | | |
| Mr. Hill | | | | | | | |

10/16/2007

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**COMMITTEE ON ENERGY AND COMMERCE -- 110TH CONGRESS**
**ROLL CALL VOTE # 42[1]**

**BILL:** H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007", as approved by the Subcommittee on Health on October 10, 2007.

**MOTION:** A Motion by Mr. Dingell to order H.R. 1424 favorably reported to the House, as amended.

**DISPOSITION: AGREED TO**, by a roll call vote of 32 yeas to 13 nays.

| REPRESENTATIVE | YEAS | NAYS | PRESENT | REPRESENTATIVE | YEAS | NAYS | PRESENT |
|---|---|---|---|---|---|---|---|
| Mr. Dingell | X | | | Mr. Barton | | X | |
| Mr. Waxman | X | | | Mr. Hall | | | |
| Mr. Markey | X | | | Mr. Hastert | | | |
| Mr. Boucher | | | | Mr. Upton | | X | |
| Mr. Towns | X | | | Mr. Stearns | | X | |
| Mr. Pallone | X | | | Mr. Deal | | X | |
| Mr. Gordon | | | | Mr. Whitfield | | X | |
| Mr. Rush | X | | | Mrs. Cubin | | | |
| Ms. Eshoo | X | | | Mr. Shimkus | X | | |
| Mr. Stupak | X | | | Mrs. Wilson | | X | |
| Mr. Engel | X | | | Mr. Shadegg | | | |
| Mr. Wynn | X | | | Mr. Pickering | X | | |
| Mr. Green | X | | | Mr. Fossella | | X | |
| Ms. DeGette | X | | | Mr. Buyer | | X | |
| Ms. Capps | X | | | Mr. Radanovich | | X | |
| Mr. Doyle | X | | | Mr. Pitts | | X | |
| Ms. Harman | | | | Ms. Bono | X | | |
| Mr. Allen | X | | | Mr. Walden | | | |
| Ms. Schakowsky | X | | | Mr. Terry | X | | |
| Ms. Solis | X | | | Mr. Ferguson | | | |
| Mr. Gonzalez | X | | | Mr. Rogers | | X | |
| Mr. Inslee | X | | | Mrs. Myrick | | | |
| Ms. Baldwin | X | | | Mr. Sullivan | | | |
| Mr. Ross | X | | | Mr. Murphy | X | | |
| Ms. Hooley | X | | | Mr. Burgess | | X | |
| Mr. Weiner | X | | | Ms. Blackburn | | X | |
| Mr. Matheson | X | | | | | | |
| Mr. Butterfield | X | | | | | | |
| Mr. Melancon | X | | | | | | |
| Mr Barrow | X | | | | | | |
| Mr. Hill | | | | | | | |

10/16/2007

[1]The recorded votes taken in Subcommittee and full Committee on H.R. 1424 (October 10 and October 16, 2007, respectively) are numbered out of sequence on the Committee on Energy and Commerce list of roll call votes for 2007. Roll call votes no. 35 through no 42 actually occurred after the Committee's roll call vote no. 29 (July 27, 2007), and should have been numbered on the list as votes no 30 through no 37

## COMMITTEE OVERSIGHT FINDINGS

Regarding clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the oversight findings of the Committee regarding H.R. 1424 are reflected in this report.

## STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The purpose of H.R. 1424 is to achieve equity in the treatment limits or the imposition of financial requirements on mental health and substance-related disorder benefits with medical and surgical benefits in group health plans or health insurance coverage offered in connection with a group health plan. The purpose is to counter a history of discrimination and stigma against mental illness and substance-related disorders that has resulted in much less access to care.

## NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Regarding compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that, over the 2008–2012 period, H.R. 1424 would result in an increase of $310 million in direct spending and a decrease of $1.1 billion in payroll tax revenue; and over the period of 2008–2017, an increase of $820 million in direct spending and a decrease of $3.1 billion in payroll tax revenue.

## EARMARKS AND TAX AND TARIFF BENEFITS

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

## COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

## CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
*Washington, DC, November 21, 2007.*

Hon. JOHN D. DINGELL,
*Chairman, Committee on Energy and Commerce,*
*House of Representatives, Washington, DC.*

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

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

Sincerely,

PETER R. ORSZAG,
*Director.*

Enclosure.

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

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

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

The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program. CBO estimates that enacting H.R. 1424 would increase federal direct spending for Medicaid by $310 million over the 2008–2012 period and by $820 million over the 2008–2017 period.

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 Internal Revenue Code (IRC) 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 Public Health Service Act (PHSA) to require that the mental health benefits of plans that choose to offer such benefits cover treatments 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). Finally, the bill would limit plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and relevant to the patient whose medical treatment is under review.

*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 the requirement to cover all conditions contained in the DSM combined with the limitation on plans' use of utilization management would probably result in an increase in employer-sponsored health insurance premiums that would be larger than if the requirement was for a minimum scope of benefits alone. However, because the provision only applies to those plans that would be affected by the PHSA, its impact on costs would likely be small. 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.

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—about 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 in-

crease federal spending for Medicaid by $310 million over the 2008–2012 period and by $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.

The bill further amends the PHSA by limiting plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and relevant to the patient whose medical treatment is under review. Because

the provision applies only to those plans who would be affected by the PHSA, its impact on costs would likely be small.

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. On October 4, 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 Ways and Means on September 26, 2007.

All three 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 for 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.

The Ways and Means and Energy and Commerce Committees' versions differ from the Education and Labor Committee's version

in that they would not include a mechanism for auditing group health plans or for providing assistance to beneficiaries of such plans. In addition, the Ways and Means and Energy and Commerce Committees' versions would amend the PHSA 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 alone 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 the estimated budgetary effects of the Ways and Means Committee's version would be identical to those of the Education and Labor Committee's version.

The Energy and Commerce Committee's version differs from the other two versions in that it would impose a restriction on plans' methods for managing utilization of mental health and substance abuse services to those that are based on valid medical evidence and are relevant to the patient whose medical treatment is under review. However, because the provision applies only to those plans that would be affected by the changes to the Public Health Service Act, its impact on costs would probably be small.

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.

## FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

## ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

## CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

## APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

## SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

### TITLE OF THE BILL

*Section 1. Short title; table of contents*

Section 1 establishes the short title of H.R. 1424 as the "Paul Wellstone Mental Health and Addiction Equity Act of 2007" and provides the table of contents of this Act.

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

Section 2 amends the Employee Retirement Income Security Act of 1974 relating to the group market. This section is not within the jurisdiction of the Committee.

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

Section 3(a) is entitled "Extension of Parity to Treatment Limits and Beneficiary Financial Requirements." This bill does not require group health plans or health insurance coverage offered in connection with such plans to offer mental health or substance related benefits. If a plan or coverage offers such benefits, however, Section 3(a) requires that it must comply with parity requirements with regard to treatment limitations and beneficiary financial requirements in the plan.

Section 3(a) amends the Public Health Service Act to prohibit group health plans or health insurance coverage offered in connection with such plans to have more restrictive treatment limitations and beneficiary financial requirements for mental health and substance-related disorders than the predominant limitation or requirement on medical and surgical disorders in specified categories. This parity requirement is only applicable in situations where substantially all medical and surgical benefits within a category have a treatment limitation or beneficiary financial requirement. The categories include (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out of network; and (5) emergency care.

In addition, Section 3(a) prohibits group health plans or health insurance coverage offered in connection with such plans from imposing treatment limits or beneficiary financial requirements on mental health services if substantially all of the medical and surgical benefits do not include any limit.

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

Section 3(b) is entitled "Expansion to Substance-Related Disorder Benefits and Revision of Definition." It includes substance-related disorder benefits in the parity requirements and definitions used in the Mental Health Parity Act under current law.

Section 3(c) is entitled "Availability of Plan Information About Criteria for Medical Necessity." It codifies that criteria for determining whether a treatment is medically necessary under the plan with respect to mental health and substance-related disorder benefits shall be available to beneficiaries.

Section 3(d) is entitled "Minimum Benefit Requirements." It requires that group health plans or health insurance coverage offered in connection with such plans that provide mental health or substance-related disorder benefits shall provide coverage of any disorder or condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. Insurance plans retain the authority in current law to define treatment benefits that are covered under the plan and the scope of those treatments for the disorders that are defined by the DSM. A "mental health benefit" as defined under current section 2705(e)(4) of the Public Health Service Act and incorporating amendments made under H.R. 1424 means "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)." This provision permits a plan to define what benefits are available for the disorders listed under the DSM that are required.

In addition, this requirement does not change the current ability of an insurer or provider to determine medically necessary and appropriate care and treatment for their patients. It merely ensures that patients are not denied mental health coverage based on the specific disorder they have. For example, a person cannot be denied coverage by their health plan merely because they have autism. A plan may determine, however, whether a treatment is medically necessary or appropriate for a given person at a given time based on their individual situation.

This section is limited to whether an insurer covers a mental health or substance-related disorder. This bill, including the minimum scope of mental health and substance-related disorder benefits in section (d) "6(A)", should not be construed to change the question of admissibility of documents or other evidence for the purpose of proving or disproving mental illness in establishing a defense of a crime. The rules of the courts or statutes of the State or the common law of the place in which the court sits and which is a part of the jurisprudence of the particular place determine the rules on admissibility of evidence for the purposes of establishing a defense to a crime. Furthermore, this bill should not change any requirements for reporting criminal conduct or create a new privilege for not reporting criminal conduct.

This bill, including the minimum scope of mental health and substance-related disorder benefits in section (d) "6(A)", should not be construed to change how determinations of disability are made under the Americans with Disabilities Act of 1990, or other Federal or State law, or an employee substance abuse policy.

Section 3(d) requires group health plans or health insurance coverage offered in connection with such plans that provide out-of-network items and services for substantially all their medical and surgical benefits within a category to also offer mental health and substance related disorder benefits for items and services in such categories furnished outside the network. The categories include (1) inpatient, (2) outpatient; and (3) emergency care.

Section 3(e) is entitled "Revision of Increased Cost Exemption." It permits group health plans or health insurance coverage offered in connection with such a plan to be exempt from the parity requirements of the bill under certain situations. Plans are exempt

if there is an increase as a result of the mental health parity act requirements in actual total costs of coverage for medical and surgical benefits and mental health and substance-related disorder benefits for one year under the plan of 2 percent or more in the first year where the parity requirements apply or 1 percent or more in subsequent years. A determination of the increase in actual total costs of coverage shall be made by a qualified and licensed actuary in good standing with the American Academy of Actuaries. Such determinations shall be made based on six months of actual cost data while the parity requirements are in place. A group health plan shall notify beneficiaries if the plan will be exempt from parity requirements.

Section 3(f) is entitled "Change in Exclusion for Smallest Employers." It excludes group health plans or health insurance issuers that serve employers with 1 to 50 employees from the treatment limitation and beneficiary financial requirement parity requirements under this bill and annual and lifetime limit parity requirements from the Mental Health Parity Act of 1996.

Section 3(g) is entitled "Elimination of Sunset Provision." It eliminates the sunset date under this bill and, thus, makes the parity requirements permanent.

Section 3(h) is entitled "Clarification Regarding Preemption." It clarifies current law, that nothing in this section preempts any State law that provides greater consumer protections, benefits, methods of access to benefits, or rights or remedies.

Section 3(i) is entitled "Conforming Amendment to Heading." It conforms section 2705 heading to be "Equity in Mental Health and Substance-Related Disorder Benefits."

Section 3(j) is entitled "Effective Date." It makes the effective date of the parity requirements in section 2705 of the Public Health Service Act the plan years beginning on or after January 1, 2008. This section also ensures that the annual and lifetime parity requirements from the Mental Health Parity Act of 1996 continue in effect even when the new parity requirements on treatment limitations and beneficiary financial requirements are not yet in effect.

Section 3(j) permits a later implementation of the parity requirements with regard to treatment limitations and beneficiary financial requirements on plans that have a collectively bargained agreement in place. Parity requirements will not be effective until the later of the dates on which the last of the collective bargaining agreements relating to the plan terminates or January 1, 2010. This later implementation date is in recognition of the sensitive nature of collective bargaining agreements.

Section 3(k) is entitled "Construction Regarding Use of Medical Management Tools." It clarifies that the Mental Health Parity Act does not alter or prohibit a health plan or health insurance issuer from using medical management tools to manage the benefit as long as such management tools are based on valid medical evidence and are relevant to the patient whose medical treatment is under review. So for example, the parity requirements do not prohibit the application of a treatment guideline that is based on valid evidence regarding the effectiveness and quality of care and is used on a patient whose condition fundamentally is the same as the condition addressed by the guideline being applied.

This construction clause applies equally to medical or surgical benefits and mental health or substance-related disorders. This construction clause should not be construed to change the burden of proof on beneficiaries, providers, or insurance plans as they exist under current law.

*Section 4. Amendments to the Internal Revenue Code of 1986*

Sections 4 amends the Internal Revenue Code of 1986. This section is not within the jurisdiction of the Committee.

*Section 5. Government Accountability Office studies and reports*

Section 5 directs the Comptroller General to study the effect of the implementation of this Act on various aspects of the healthcare system, including (1) access to health insurance coverage; (2) the quality of such coverage, Medicare, Medicaid, and State and local mental health and substance abuse treatment spending; (3) the number of individuals with private insurance receiving publicly-funded health care for mental health and substance-related disorders; (4) spending on public services such as the criminal justice system, special education, and income assistance programs; (5) the use of medical management of mental health and substance-related disorder benefits and medical necessity determinations by group health plans; (6) and any other matters the Comptroller General believes appropriate. The report must be submitted to Congress two years after the enactment of H.R. 1424.

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

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SHORT TITLE AND TABLE OF CONTENTS

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

TABLE OF CONTENTS

Sec. 1. Short title and table of contents.

* * * * * * *

PART 7—GROUP HEALTH PLAN REQUIREMENTS

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

Sec. 701. Increased portability through limitation on preexisting condition exclusions.

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SUBPART B—OTHER REQUIREMENTS

Sec. 711. Standards relating to benefits for mothers and newborns.

[Sec. 712. Parity in the application of certain limits to mental health benefits.]
*Sec. 712. Equity in mental health and substance-related disorder benefits.*

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART B—OTHER REQUIREMENTS

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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 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.

*(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.*

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

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

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

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

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

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

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

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

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

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

(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.

(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 mate-*

*rial 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) * * *

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(3) MEDICAL OR SURGICAL BENEFITS.—The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan 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) 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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## SECTION 2705 OF THE PUBLIC HEALTH SERVICE ACT

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

***SEC. 2705. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.***

(a) IN GENERAL.—

(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and **[**mental health benefits**]** *mental health or substance-related disorder benefits*—

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

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

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

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

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to [mental health benefits] *mental health or substance-related disorder benefits* by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) ANNUAL LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and [mental health benefits] *mental health or substance-related disorder benefits*—

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

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

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

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

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph

(A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to [mental health benefits] *mental health or substance-related disorder benefits* by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

*(3) TREATMENT LIMITS.—*

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

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

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

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

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

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

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

*(v) EMERGENCY CARE.—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the*

*treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health and substance-related disorders).*

*(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term "treatment limit" means, with respect to a plan or coverage, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan or coverage.*

*(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or financial requirement with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of limit or requirement with respect to such category of items and services.*

*(4) BENEFICIARY FINANCIAL REQUIREMENTS.—*

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

*(B) BENEFICIARY FINANCIAL REQUIREMENT.—*

*(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.*

*(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that 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 or substance-related disorder benefits, the plan or coverage 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 (or health insurance coverage offered in connection with such 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 in clause (ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.*

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

*and surgical benefits and all mental health and substance-related disorder benefits shall be classified into one of the following categories:*

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

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

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

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

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

⟦(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).⟧

(c) EXEMPTIONS.—

(1) SMALL EMPLOYER EXEMPTION.—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 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 (or coverage) 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 (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 a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.*

* * * * * * *

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

(1) * * *

* * * * * * *

(3) MEDICAL OR SURGICAL BENEFITS.—The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include **[**mental health benefits**]** *mental health or substance-related disorder benefits*.

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

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

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

*(1) IN GENERAL.—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. 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 and substance-related disorder benefits*—

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

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

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

benefits] *mental health and substance-related disorder benefits*; or

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

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to [mental health benefits] *mental health and substance-related disorder benefits* by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

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

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

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

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

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

(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan with respect to [mental health benefits] *mental health and substance-related disorder benefits* by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

*(3) TREATMENT LIMITS.—*

*(A) NO TREATMENT LIMIT.—If the plan does not include a treatment limit (as defined in subparagraph (D)) on sub-*

*stantially all medical and surgical benefits in any category of items or services (specified in subparagraph (C)), the plan may not impose any treatment limit on mental health and substance-related disorder benefits that are classified in the same category of items or services.*

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

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

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

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

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

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

*(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term "treatment limit" means, with respect to a plan, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan.*

*(E) PREDOMINANCE.—For purposes of this subsection, a treatment limit or financial requirement with respect to a category of items and services is considered to be predominant if it is the most common or frequent of such type of limit or requirement with respect to such category of items and services.*

*(4) BENEFICIARY FINANCIAL REQUIREMENTS.—*

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

*impose such a beneficiary financial requirement on mental health and substance-related disorder benefits for items and services within such category.*

*(B) BENEFICIARY FINANCIAL REQUIREMENT.—*

*(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.*

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

*(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term "beneficiary financial requirement" includes, with respect to a plan, any deductible, coinsurance, co-payment, other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan, but does not include the application of any aggregate lifetime limit or annual limit.*

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

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

*(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group*

*health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, with the highest average enrollment as of the beginning of the most recent year beginning on or before the beginning of the plan year involved.*

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

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

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

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

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

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

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

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

**[**(2) in the case of a group health plan that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan, except as specifically provided in subsection (a)

(in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).]

(c) EXEMPTIONS.—

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

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

*(1) SMALL EMPLOYER EXEMPTION.—*

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

*(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term "small employer" means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.*

*(2) INCREASED COST EXEMPTION.—*

*(A) IN GENERAL.—With respect to a group health plan, if the application of this section to such plan results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan during the following plan year, and such exemption shall apply to the plan for 1 plan year.*

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

*(i) 2 percent in the case of the first plan year which begins after the date of the enactment of the Paul Wellstone Mental Health and Addiction Equity Act of 2007; and*

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

*(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan for purposes of this subsection shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.*

*(D) 6-MONTH DETERMINATIONS.—If a group health plan seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan has*

*complied with this section for the first 6 months of the plan year involved.*

* * * * * * *

(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 and substance-related disorder benefits*.

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

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

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

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

[(3) after December 31, 2007.]

* * * * * * *

## DISSENTING VIEWS

We could not support H.R. 1424 as passed by the Committee because it is a seriously flawed bill. If enacted, the bill will likely result in fewer employers providing any mental health benefits and overly prescriptive rules governing what benefits may be provided. Congress should not impose complicated decision rules that govern the relationship between various categories of items or services in private sector health insurance. Micromanaging private sector health insurance will result in mediocrity in mental health services, increased costs, and more uninsured individuals.

The free market is capable of forming appropriate financial requirements and other limitations in health insurance that produce the best combination of price structure and value for consumers in an ever-changing medical world. The practice of psychology and psychiatry and its relationship to physical health is very different today than a decade ago; this will undoubtedly be true a decade from now as well. The lines between mental health and physical health often blur. The lines between behavior that is criminal, social, medical, and non-medical will change over time. For insurance companies to effect quality control, proper pricing, and the best value, insurance policies must also adjust with these shifting lines. The more we restrict the marketplace from adjusting accordingly, the more we replace common sense and market expertise with political judgment.

Health benefits, including mental health benefits, fall into different categories for purposes of insurance coverage. These categories may have different financial requirements, treatment limitations, or exclusions from coverage. Even outside of mental health benefits, health plans do not treat all categories of health benefits alike. For example, outpatient physical therapy, emergency care, specialty care, speech therapy, occupational care, chiropractic care, and preventive care often have different limitations than other services. Prescription drugs may also have different categories of co-payments. The fact that there are requirements tailored by category is not a civil rights issue. Micromanaging these categories into columns and applying complicated rules to such categories has no rational basis. And yet that is exactly what this bill will do. Will Congress turn next to oncology parity, dental parity, physical therapy parity, laboratory parity, payment parity, training parity, or medical evidence parity? One need only look at the extraordinarily complicated rules of the 1996 Mental Health Parity Act to understand that their application to each and every financial requirement and each and every treatment limit makes little sense. It is hard to see why Congressional intervention in such a complicated and dynamic area as mental health coverage is helpful or wise.

THE MAJORITY HAS PROVIDED NO BUDGET OFFSET AND THE CONGRESSIONAL BUDGET OFFICE STATES THAT SOME EMPLOYERS WILL DROP INSURANCE AND REDUCE BENEFITS

The Congressional Budget Office (CBO) currently scores the bill as increasing direct spending by $310 million over the 2008–2012 period and $820 million over the 2008–2017 period. There would also be a reduction in federal tax revenues of $3.1 billion over the 2008–2017 period. The Majority has not proposed an offset. Before we vote on items that have budget impacts, we would like to know from where the money will come. The last time the Majority searched for an offset, they proposed to cut seniors' Medicare coverage by $193 billion.

The CBO projects this bill will result in people losing health insurance benefits and some employers terminating mental health benefits altogether. The CBO also estimates that H.R. 1424 will 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. These responses would include "reductions 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 benefits, such as increased deductibles or higher co-payments".

PROTAGONISTS HAVE MADE LITTLE ATTEMPT TO ADDRESS THE CONCERNS OF EMPLOYERS, INSURERS, OR THE ADMINISTRATION

Setting aside the question of the wisdom of this approach, it is hard to imagine a more poorly drafted piece of legislation than H.R. 1424 as reported out of the Committee. We offered many amendments that would have improved this piece of legislation. The Democrat majority rejected each of these amendments. This approach is in marked contrast to the Senate, which went through a long process of negotiations that included employers, insurers, the National Alliance for the Mentally Ill, the Fairness Coalition, and many other groups to achieve a balanced and more workable proposal. We are unaware of any attempt to work with employers and insurers to address their concerns. The House bill is simply a way for the Democrat Majority to challenge the more balanced Senate agreement.

Employers, insurers, and human resource groups oppose H.R. 1424. For example, the National Retail Federation, Aetna, the American Benefits Council, the U.S. Chamber of Commerce, the Blue Cross Blue Shield Association, the National Association of Health Underwriters, the National Association of Wholesaler-Distributors, the Society for Human Resource Management, the National Association of Manufacturers, the Retail Industry Leaders Association, the National Business Group on Health, the National Restaurant Association, and the Corporate Health Care Coalition have all signed a letter in opposition to H.R. 1424. Many members of these groups voluntarily provide health insurance benefits as a form of compensation. They do not have to provide mental health

benefits if the costs are unreasonable, the regulations too onerous, or the liabilities too great. They stated:

> We write in joint and strong opposition to H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. We urge you to adopt the language of the Senate passed parity bill, S. 558, the Mental Health Parity Act, in its stead. We strongly oppose H.R. 1424, principally because of its broad benefit mandate (DSMIV), its lack of adequate protection for the medical management of benefits, provisions allowing the states to enact more extensive provisions including an alternative remedy structure, and provisions mandating out-of-network coverage. The substitute amendment adopted during the Health Subcommittee markup on October 10, 2007 has made this legislation significantly worse. Protecting only medical management techniques which "are based on valid medical evidence" establishes a vague standard which is certain to invite litigation. In addition, the substitute amendment explicitly confirms the DSM-IV mandate and applies the mandate to emergency services. Further, the subcommittee substitute amendment failed to eliminate the bill's out-of-network mandate or the authority for states to establish new remedies, both of which remain key concerns for employers and health plans. The undersigned organizations supported the bipartisan Senate negotiations which resulted in a more balanced compromise proposal. We cannot support and will continue to work to defeat H.R. 1424 as introduced and subsequently amended. Again, we strongly oppose the House bill, H.R. 1424, and urge its defeat in the full House Energy and Commerce Committee. We urge your support instead for individual or substitute amendments containing the language of the parity bill passed by a unanimous Senate: S. 558, the Mental Health Parity Act.

The ERISA Industry Committee, also composed of groups who provide voluntary coverage, testified:

> ERIC members are broadly in favor of expanding coverage, but the approach contained within H.R. 1424 is fundamentally flawed. The bill fails to incentivize better coverage options, instead injecting government into the world of voluntary benefits, creating mandates, micromanaging the distribution of benefits, failing to protect plan sponsors from burdensome and costly administrative quagmires, and failing to keep up with innovations and demands already widely accepted in the private health benefits marketplace.

In a letter dated September 26, 2007, Department of Labor Secretary Chao and Department of Health and Human Services Secretary Leavitt, the heads of the two Departments charged with administering the parity program, wrote:

> We are concerned that competing proposals, such H.R. 1424, could have a negative effect on the accessibility and affordability of employer-provided health benefits. These

> proposals would mandate coverage of a broad range of diseases and conditions and undermine current law that provides for the uniform administration of employee benefit plans.

The Senate worked with the Administration to craft its policy. We should do the same. In both the subcommittee and full committee markups, Ms. Wilson offered an amendment to replace the parity rule in H.R. 1424 pertaining to plans that fall under both the Public Health Service Act and the jurisdiction of this committee with the parity rule from S. 558. Her amendments were defeated, largely along party lines.

DELEGATING THE POWER TO EXPAND COVERAGE MANDATES TO THE AMERICAN PSYCHIATRIC ASSOCIATION IS A FUNDAMENTAL CONFLICT OF INTEREST AND PROBABLY UNCONSTITUTIONAL

H.R. 1424 as reported delegates the potential expansion of coverage requirements in the private sector to the American Psychiatric Association (APA). Under the bill, no Executive or Congressional action would intercede between the decisions of the American Psychiatric Association and future legal requirements with which employers and insurers must comply under penalty of Federal law. Not only does the Committee amendment reflect a failure to recognize a basic conflict of interest, it also likely presents a Constitutional conflict under the Delegations doctrine. The bill appears to leave any update of what qualifies as conditions and, therefore, coverage to the APA. There are no criteria for judicial review. There are no opportunities for notice and comment required. There are no Federal restrictions on conflict of interest. There are no requirements to distinguish between mental disorders and conditions of clinical focus. The Committee amendment is an abrogation of both Legislative branch and Executive branch roles to a group lobbying for this bill.

THE MAJORITY AMENDMENT FAILS TO REFLECT THAT CONDITIONS OF CLINICAL FOCUS ARE NOT MENTAL DISORDERS PER SE AND ARE NOT BASED ON DIAGNOSTIC CRITERIA

The adoption of an over 880-page manual produces numerous problems. The Majority fails to understand or recognize the difference between a mental disorder and a condition of clinical focus. Then Chairman Bilirakis of the Health Subcommittee asked about this issue in a 2002 hearing. The APA witness answered, among other things that:

> This question focuses on a section of the DSM–IV that is called "Other Conditions That May be a Focus of Clinical Attention." Only a general description of these conditions is provided because these conditions *are not mental disorders per se and thus do not have specific criteria governing their inclusion or exclusion.* . . . [I]nclusion of the V Codes is provided as a courtesy to facilitate coding and crosswalking between ICD and DSM and allows clinicians an opportunity to identify the types of *"non-diagnostic"* problems that are brought to their attention . . .

> . . . While it is true that no specific scientific evidence is provided in DSM–IV or ICD–9–CM for conditions that are the focus of clinical attention, the V-code conditions are simply lists that have been accumulated over the years to describe the reasons why patients might come to a physician or other health care provider's office. They are coded and given a number so that statistical analyses can be made for research that is intended to improve the organization and effectiveness of meeting patient needs and requests. [emphasis added].

So exactly what is the mandate for "non-diagnostic problems" that are not mental disorders? The Majority's approach places conditions of focus at the same level as mental disorders. This is not supported by science or medical evidence. Mr. Burgess offered an amendment to address this issue which the Majority defeated. To be clear, the purpose of the amendment is not to enable insurers' denial of claims because a provider also cites a condition of clinical focus; rather, it would clarify that a condition of clinical focus should not itself be the basis of a Congressional coverage mandate.

The Majority fails to understand that mental disorders under DSM IV are essentially defined by diagnostic criteria. That means Congress is incorporating by reference actual mental health diagnostic criteria as a provision of Federal law. Even within each diagnostic criterion for the disorders there are statements about what represents clinical significance. We are unaware of a precedent for Congress defining diagnostic criteria.

THE MAJORITY'S BLANKET INCLUSION OF DSM–IV CONDITIONS MAY EXPAND CRIMINAL DEFENSES AND AFFECT CRIMINAL REPORTING REQUIREMENTS, DISABILITIES LAWS, AND EMPLOYEE SUBSTANCE ABUSE POLICIES

The Majority would have Congress codify DSM–IV in three separate Federal statutes. It is true these statutes are not themselves general criminal statutes, disabilities laws, or substance abuse policies. However, make no mistake about it, criminal defense lawyers and disabilities lawyers will cite the codification of DSM–IV as Congressional intention that all DSM–IV conditions have a legal status under Federal law, lending additional weight to their pleadings. Other lawyers will claim the inclusion of these categories in statute means certain information is restricted under medial privacy laws, or that DSM–IV conditions are all disabilities requiring coverage.

For instance, criminal conduct forms the basis of the category "V 71.01 Adult Antisocial Behavior":

> This category can be used when the focus of clinical attention is adult antisocial behavior that is not due to a mental disorder (e.g., Conduct Disorder, Antisocial Personality Disorder, or Impulse-Control Disorder). Examples include the behavior of professional thieves, racketeers, or dealers in illegal substances.

"V. 61.21, Physical Abuse of Children and Sexual Abuse of Children" is a similar example. Again, these categories include criminal behavior and no further diagnostic criterion remains necessary.

What is a court to conclude? That Congress appears to expand or lend support to the frequent claim that criminal behavior is essentially a mental health condition requiring treatment. Why would a court conclude this? Because of the rule of construction on which courts sometimes rely, called *in pari materia,* which means "upon the same matter or subject." When a statute is ambiguous, its meaning may be determined in light of other statutes on the same subject matter. We do not want a defense lawyer citing the Congressional decision to codify DSM conditions as an element of the defense to a crime, but that will be an inevitable result of H.R. 1424.

Mr. Stearns offered a common sense amendment, which provided that the act of codification of DSM would not create a defense in a criminal case, including cases of child abuse. The amendment also provided the act of codification of DSM would not override any requirements for reporting criminal conduct, including child abuse, nor create any new privilege against disclosure. Unfortunately, the Majority voted down this important amendment as well.

Mr. Rogers of Michigan offered a similar rule of construction as an amendment to ensure that no provision of the Act would restrict a plan from denying a claim for any person convicted of child abuse or other criminal activity who cites that conviction as the basis of a mental health condition claim. The Majority voted down this amendment, too.

In addition to codes based on criminal conduct, the DSM–IV contains codes based on other non-medical issues:

V62.3 ACADEMIC PROBLEM

> This category can be used when the focus of clinical attention is an academic problem that is not due to a mental disorder or, if due to a mental disorder, is sufficiently severe to warrant independent clinical attention. An example is a pattern of failing grades or of significant underachievement in a person with adequate intellectual capacity in the absence of a Learning or Communication Disorder or any other mental disorder that would account for this problem.

V62.89 RELIGIOUS OR SPIRITUAL PROBLEM

> This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.

V. 62.4 ACCULTURATION PROBLEM

This category can be used when the focus of clinical attention is a problem involving adjustment to a different culture (e.g., following migration).

Under the Majority's formulation, H.R. 1424 would require an insurance policy cover these non-medical problems. There are no diagnostic criteria in these conditions. Part of why the private sector and public sector have developed financial requirements and treatment limits by categories is to provide value and ensure quality. Employers negotiate on behalf of beneficiaries for a balanced package of health care coverage. Insurers negotiate under free market competition to get the best packages. The cornerstone of this approach is to focus on serious medical conditions. Less serious or mild versions of items listed in the DSM are just not the same as serious medical conditions such as heart attacks, cancer, or severe mental illnesses. If companies are forced to spend more money on items like spiritual problems, academic problems, or a wide range of other items that may not be medically-based, we will undermine this system.

If by passing H.R. 1424, Congress is mandating coverage for these non-medical problems, are we also saying the same non-medical problems could constitute disabilities for other purposes? There are plenty of creative disabilities lawyers. These lawyers could say "my client has serious religious problem or a serious acculturation problem and accommodations under the law must be made accordingly." We need to make absolutely sure that we are not expanding the universe of claims under disabilities law. A clear savings clause in the text would accomplish that goal. Mr. Burgess offered such an amendment. That language should be included in the bill before this measure reaches the House floor.

Turning to the concern about employee substance abuse policies, is it the position of the Majority that an employee can continue to violate a company's substance abuse policy and be rewarded for it merely because the DSM–IV cites substance abuse as a condition? Explain this to the small business owner or his employees when he or she is forced to increase premiums, or drop health insurance coverage altogether, because Federal law forces him or her to pay for people in violation of the company substance abuse policy. All of these clarifications need to be addressed in the text of the legislation, not simply legislative history.

THE COMPLICATED DECISION RULES UNDER H.R. 1424 DO NOT MATCH THE PARITY GUIDANCE UNDER THE FEDERAL EMPLOYEE BENEFITS PLAN AND WILL PRODUCE IRRATIONAL RESULTS

Despite the claims of protagonists, it is clear from the text as well as the answers to questions during the markup that H.R. 1424 is not a set of parity rules at all. The provisions do not operate like the parity guidance from the Federal Employees Health Benefit Plans (FEHBP). Under the FEHBP parity guidance, a plan can satisfy parity if a subcategory of items or services does not make a distinction in its application between mental health benefits or non-mental health benefits, or where subcategories of mental health benefits have the same requirements as comparable subcat-

egories of non-mental health benefits. We read the rules proposed by H.R. 1424 as potentially trumping this common sense FEHBP rule. As we review proposed paragraphs 2705(a)(3)(A) and (4)(A) of the Public Health Service Act, we find situations where a plan may not impose ANY financial requirement or treatment limitation unless such requirement or limitation is imposed on substantially all items in distinct super categories defined by the bill. This means even if a subcategory of mental health benefits has the same requirements as a comparable category of non-mental health benefits, a plan may still be in violation of (3)(A) and (4)(A). What is the policy rationale for this rule? We are not aware of any.

A similar problem exists under proposed 2105(a)(3)(B) and (4)(B). For example under (4)(B) a mental health benefit cannot have a more costly requirement than what applies to the predominant requirement for items or services within the specified super categories. Since the predominant requirement is not necessarily from a comparable subcategory this means identical requirements from similar subcategories may fail to satisfy the tests of (3)(B) and (4)(B).

We understand that under (3)(A) and (4)(A) a plan may then not be able to apply any financial requirements or treatment limitations to mental health benefits if the frequency of items or services is not sufficiently large to meet a certain level. So how would that apply here? Such a rule would seem to suggest that even if there are identical requirements for similar subcategories a plan may still be in violation of (3)(A) and (4)(A).

We also asked if a psychiatrist is generally considered a specialist, but the $15 co-pay is the most frequent in out-patient in-network coverage and it is considered predominant, would this bill end up saying the $15 co-pay or the $50 co-pay applies? We had hoped the answer would be that similar subcategories, like co-pays for specialist could be treated similarly. However, H.R. 1424 would ensure the predominance rule would trump the rule about similar categories. This is not parity.

We specifically queried the Office of Personnel Management regarding this issue. They responded with the following technical comments:

> H.R. 1424 lists 5 major (predominant) categories of items and services where treatment limits and financial requirements for mental health and substance disorder benefits can be no more restrictive for patients than the predominant benefit categories. These predominant categories are not used to describe benefits in FEHB plans and do not take into consideration sub-categories of benefits where treatment limits and financial requirements typically vary. OPM has not estimated the financial impact that the "predominant" provision would have on FEHB premiums, because we do not know how the legislation would be implemented in practice. However, we believe premium costs would increase as a result.
>
> Under the FEHB Program, the common categories of items and services for the purpose of applying treatment limits and financial requirements of medical and surgical benefits to mental health and substance abuse benefits

> are: Inpatient hospital, Outpatient hospital, Outpatient specialist physician (professional), Laboratory and X-ray tests, Surgical services, Prescription drugs, and Emergency services. Generally, benefits are provided based on type of provider and place of service. Type of provider includes the contractual relationship the provider has with the health plan (e.g. preferred provider).
>
> Under the FEHB Program, health plans may use managed care techniques, such as authorizing treatment plans, to ensure the most cost-efficient delivery of benefits for mental health and substance abuse services. Patient treatment plans are developed by providers and are subject to review and approval by the health plan.
>
> H.R. 1424, as passed by the House Committee on Energy & Commerce on October 16th, would impact the FEHB Program in one key area, the addition of parity out-of-network mental health and substance abuse benefits for those health plans that offer out-of-network benefits. Under FEHB, health plans are not required to provide parity for out-of-network mental health and substance abuse benefits. OPM estimates that requiring out-of-network parity will increase costs to the FEHB Program by $50 million. We believe we have successfully met the needs of the Federal population through our approach to offering parity on an in-network basis.

Mr. Deal offered a simple amendment, which ensured a plan following the current FEHBP guidelines would satisfy the parity requirements under the bill. The Majority rejected the amendment. Apparently, the program available to Members of Congress was not good enough.

### Arguments Regarding the Discretion of Plans To Manage Treatment Plans and the Burden of Producing Medical Evidence Will Be the Source of Endless Litigation

Under FEHBP, plan benefits are payable only when the plan determines the care is clinically appropriate and approved in a treatment plan. Insurers may limit parity benefits when patients do not substantially follow their treatment plans. Providers need to show that a medical diagnosis is supported by medical evidence and that a proposed treatment is medically necessary and appropriate. That is a proper obligation. Payors and insurers should not be forced to disprove the negative. It is not the job of insurers to show by medical evidence that a patient does not have mental health problem. It is not the job of insurers to show by medical evidence that a treatment is not medically necessary. Switching this presumption from providers to insurers is no small matter and is not good policy.

### The Cost Exemption Under H.R. 1424 Is Not a Realistic Option

Under the language of the bill, once it is proven through actual cost increases that plan costs are above a certain percentage, an employer could have a waiver of the parity requirement. But that

would only be available for 1 year. After 1 year, the employer or insurer must go back to the parity rule and suffer the cost increase for another period of time. After that second period of time, the employer or insurer could then get a waiver for the following year. The employer's or insurer's eligibility for a waiver would continue to alternate every other year.

This is a policy that works like a yo-yo: 1 year in, 1 year out, followed by another year in. It is very difficult to imagine any business exercising this option, with all of its attendant administrative burdens, in the real world. It seems far more likely employers will either absorb elevated costs on a permanent basis or drop mental health coverage altogether. That will hurt both businesses and beneficiaries who lose mental health coverage.

## A LOT OF WORK IS NEEDED ON THIS BILL

We submit a substantial list of dissenting views in order to prompt Members to think about the drafting of this legislation and its potential unintended consequences. There are other problems we have not discussed in these views. For instance, if Congress is serious about addressing treatment disparities for Americans with severe mental illnesses such as bipolar disorder, schizophrenia, and depression, we should focus on legislation that would bolster this coverage rather than insisting on full coverage of the DSM–IV, which will drive some employers to drop benefits. It would be smarter to craft a policy that would address the most severe mental illnesses with sufficient support from employers to counter CBO's projections about lost coverage and benefits. We think the best approach is to engage stakeholders—employers, insurers, the Administration, and other parties—to solve the problems of the H.R. 1424 text before the bill reaches the House floor. We know the House and the Committee can do a much better job.

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