

110TH CONGRESS  
1ST SESSION

# H. R. 1367

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.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 7, 2007

Mr. KENNEDY (for himself, Mr. RAMSTAD, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ALEXANDER, Mr. ALLEN, Mr. ANDREWS, Mr. ARCURI, Mr. BACA, Mr. BACHUS, Mr. BAIRD, Ms. BALDWIN, Mr. BARROW, Ms. BEAN, Mr. BECERRA, Ms. BERKLEY, Mr. BERMAN, Mr. BERRY, Mr. BISHOP of Georgia, Mr. BISHOP of New York, Mr. BLUMENAUER, Ms. BORDALLO, Mr. BOREN, Mr. BOSWELL, Mr. BOUCHER, Mr. BOYD of Florida, Mr. BRADY of Pennsylvania, Mr. BRALEY of Iowa, Ms. CORRINE BROWN of Florida, Mr. BUTTERFIELD, Mrs. CAPPS, Mr. CAPUANO, Mr. CARDOZA, Mr. CARNAHAN, Mr. CARNEY, Ms. CARSON, Ms. CASTOR, Mr. CHANDLER, Mrs. CHRISTENSEN, Ms. CLARKE, Mr. CLAY, Mr. CLEAVER, Mr. CLYBURN, Mr. COHEN, Mr. CONYERS, Mr. COOPER, Mr. COSTA, Mr. COSTELLO, Mr. COURTNEY, Mr. CROWLEY, Mrs. CUBIN, Mr. CUELLAR, Mr. CUMMINGS, Mr. DAVIS of Alabama, Mr. DAVIS of Illinois, Mrs. DAVIS of California, Mr. LINCOLN DAVIS of Tennessee, Mr. DEFazio, Ms. DEGETTE, Mr. DELAHUNT, Ms. DELAURO, Mr. DICKS, Mr. DOGGETT, Mr. DOYLE, Mr. EDWARDS, Mr. ELLISON, Mr. ELLSWORTH, Mr. EMANUEL, Mrs. EMERSON, Mr. ENGEL, Mr. ENGLISH of Pennsylvania, Ms. ESHOO, Mr. ETHERIDGE, Mr. FALEOMAVAEGA, Mr. FARR, Mr. FATTAH, Mr. FERGUSON, Mr. FILNER, Mr. FRANK of Massachusetts, Mr. FRELINGHUYSEN, Mr. GERLACH, Ms. GIFFORDS, Mr. GILCHREST, Mrs. GILLIBRAND, Mr. GONZALEZ, Mr. GORDON of Tennessee, Mr. AL GREEN of Texas, Mr. GENE GREEN of Texas, Mr. GRIJALVA, Mr. GUTIERREZ, Mr. HALL of New York, Mr. HARE, Ms. HARMAN, Mr. HASTINGS of Florida, Ms. HERSETH, Mr. HIGGINS, Mr. HINCHEY, Mr. HINOJOSA, Ms. HIRONO, Mr. HODES, Mr. HOLDEN, Mr. HOLT, Mr. HONDA, Ms. HOOLEY, Mr. HOYER, Mr. INSLEE, Mr. ISRAEL, Mr. JACKSON of Illinois, Ms. JACKSON-LEE of Texas, Mr. JEFFERSON, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSON of Georgia, Mrs. JONES of Ohio, Mr. KAGEN, Mr. KANJORSKI, Ms. KAPTUR, Mr. KELLER of Florida, Mr. KILDEE, Ms. KILPATRICK, Mr. KIND, Mr. KING of New

York, Mr. KIRK, Mr. KLEIN of Florida, Mr. KUCINICH, Mr. LAHOOD, Mr. LAMPSON, Mr. LANGEVIN, Mr. LANTOS, Mr. LARSEN of Washington, Mr. LARSON of Connecticut, Mr. LATOURETTE, Ms. LEE, Mr. LEVIN, Mr. LEWIS of Georgia, Mr. LIPINSKI, Mr. LoBIONDO, Mr. LOEBSACK, Ms. ZOE LOFGREN of California, Mrs. LOWEY, Mr. LYNCH, Mrs. MALONEY of New York, Mr. MARKEY, Mr. MARSHALL, Mr. MATHESON, Ms. MATSUI, Mrs. MCCARTHY of New York, Ms. MCCOLLUM of Minnesota, Mr. McDERMOTT, Mr. MCGOVERN, Mr. McHUGH, Mr. McINTYRE, Mr. McNERNEY, Mr. McNULTY, Mr. MEEHAN, Mr. MEEK of Florida, Mr. MEEKS of New York, Mr. MICA, Mr. MICHAUD, Ms. MILLENDER-MCDONALD, Mr. GEORGE MILLER of California, Mr. MOLLOHAN, Mr. MOORE of Kansas, Ms. MOORE of Wisconsin, Mr. MORAN of Virginia, Mr. MURPHY of Connecticut, Mr. TIM MURPHY of Pennsylvania, Mr. MURTHA, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEAL of Massachusetts, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OLVER, Mr. ORTIZ, Mr. PALLONE, Mr. PASCRELL, Mr. PASTOR, Mr. PAYNE, Mr. PERLMUTTER, Mr. PETERSON of Minnesota, Mr. PICKERING, Mr. PLATTS, Mr. POMEROY, Mr. PRICE of North Carolina, Mr. RAHALL, Mr. RANGEL, Mr. RENZI, Mr. REYES, Mr. RODRIGUEZ, Ms. ROS-LEHTINEN, Mr. ROSS, Mr. ROTHMAN, Ms. ROYBAL-ALLARD, Mr. RUPPERSBERGER, Mr. RUSH, Mr. RYAN of Ohio, Mr. SALAZAR, Ms. LINDA T. SÁNCHEZ of California, Ms. LORETTA SANCHEZ of California, Mr. SARBANES, Mr. SAXTON, Ms. SCHAKOWSKY, Mr. SCHIFF, Mrs. SCHMIDT, Ms. WASSERMAN SCHULTZ, Ms. SCHWARTZ, Mr. SCOTT of Georgia, Mr. SCOTT of Virginia, Mr. SERRANO, Mr. SESTAK, Mr. SHAYS, Ms. SHEAPORTER, Mr. SHERMAN, Mr. SIRES, Mr. SKELTON, Ms. SLAUGHTER, Mr. SMITH of Washington, Mr. SMITH of New Jersey, Mr. SNYDER, Ms. SOLIS, Mr. SPACE, Mr. SPRATT, Mr. STARK, Mr. STUPAK, Mr. SULLIVAN, Ms. SUTTON, Mr. TANNER, Mrs. TAUSCHER, Mr. THOMPSON of Mississippi, Mr. THOMPSON of California, Mr. TIERNEY, Mr. TOWNS, Mr. UDALL of Colorado, Mr. UDALL of New Mexico, Mr. UPTON, Mr. VAN HOLLEN, Ms. VELÁZQUEZ, Mr. VISCLOSKY, Mr. WALSH of New York, Mr. WALZ of Minnesota, Mr. WAMP, Ms. WATERS, Ms. WATSON, Mr. WATT, Mr. WAXMAN, Mr. WEINER, Mr. WELCH of Vermont, Mr. WEXLER, Mr. WILSON of Ohio, Mr. WILSON of South Carolina, Ms. WOOLSEY, Mr. WU, Mr. WYNN, Mr. YARMUTH, and Mr. YOUNG of Alaska) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Labor and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health

Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

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

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

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

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

Sec. 1. Short title; table of contents.

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

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

Sec. 5. Amendments to the Internal Revenue Code of 1986.

Sec. 5. Government Accountability Office studies and reports.

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

11       (a) **EXTENSION OF PARITY TO TREATMENT LIMITS**  
 12       **AND BENEFICIARY FINANCIAL REQUIREMENTS.**—Section  
 13       712 of the Employee Retirement Income Security Act of  
 14       1974 (29 U.S.C. 1185a) is amended—

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

17               “(3) **TREATMENT LIMITS.**—

18                       “(A) **NO TREATMENT LIMIT.**—If the plan  
 19       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

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

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

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

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

21 “(iv) OUTPATIENT, OUT-OF-NET-  
22 WORK.—Items and services furnished on  
23 an outpatient basis and outside any net-  
24 work of providers established or recognized  
25 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

1 disorder benefits for items and services within  
2 such category.

3 “(B) BENEFICIARY FINANCIAL REQUIRE-  
4 MENT.—

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

1           mental health and substance-related dis-  
2           order benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

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

11          “(E) NOTIFICATION.—An election to mod-  
12          ify coverage of mental health and substance-re-  
13          lated disorder benefits as permitted under this  
14          paragraph shall be treated as a material modi-  
15          fication in the terms of the plan as described in  
16          section 102(a)(1) and shall be subject to the  
17          applicable notice requirements under section  
18          104(b)(1).”.

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

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

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

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

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

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

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

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

19       (i) CONFORMING AMENDMENTS TO HEADING.—

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

22       **“SEC. 712. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**  
23       **RELATED DISORDER BENEFITS.”.**

24          (2) CLERICAL AMENDMENT.—The table of con-  
25       tents in section 1 of such Act is amended by striking



1 the item relating to section 712 and inserting the  
 2 following new item:

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

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

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

8 (a) EXTENSION OF PARITY TO TREATMENT LIMITS  
 9 AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section  
 10 2705 of the Public Health Service Act (42 U.S.C. 300gg–  
 11 5) is amended—

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

14 “(3) TREATMENT LIMITS.—

15 “(A) NO TREATMENT LIMIT.—If the plan  
 16 or coverage does not include a treatment limit  
 17 (as defined in subparagraph (D)) on substan-  
 18 tially all medical and surgical benefits in any  
 19 category of items or services (specified in sub-  
 20 paragraph (C)), the plan or coverage may not  
 21 impose any treatment limit on mental health  
 22 and substance-related disorder benefits that are  
 23 classified in the same category of items or serv-  
 24 ices.

1           “(B) TREATMENT LIMIT.—If the plan or  
2 coverage includes a treatment limit on substan-  
3 tially all medical and surgical benefits in any  
4 category of items or services, the plan or cov-  
5 erage may not impose such a treatment limit on  
6 mental health and substance-related disorder  
7 benefits for items and services within such cat-  
8 egory that are more restrictive than the pre-  
9 dominant treatment limit that is applicable to  
10 medical and surgical benefits for items and  
11 services within such category.

12           “(C) CATEGORIES OF ITEMS AND SERV-  
13 ICES FOR APPLICATION OF TREATMENT LIMITS  
14 AND BENEFICIARY FINANCIAL REQUIRE-  
15 MENTS.—For purposes of this paragraph and  
16 paragraph (4), there shall be the following four  
17 categories of items and services for benefits,  
18 whether medical and surgical benefits or mental  
19 health and substance-related disorder benefits,  
20 and all medical and surgical benefits and all  
21 mental health and substance related benefits  
22 shall be classified into one of the following cat-  
23 egories:

24           “(i) INPATIENT, IN-NETWORK.—Items  
25 and services furnished on an inpatient

1 basis and within a network of providers es-  
2 tablished or recognized under such plan or  
3 coverage.

4 “(ii) INPATIENT, OUT-OF-NETWORK.—  
5 Items and services furnished on an inpa-  
6 tient basis and outside any network of pro-  
7 viders established or recognized under such  
8 plan or coverage.

9 “(iii) OUTPATIENT, IN-NETWORK.—  
10 Items and services furnished on an out-  
11 patient basis and within a network of pro-  
12 viders established or recognized under such  
13 plan or coverage.

14 “(iv) OUTPATIENT, OUT-OF-NET-  
15 WORK.—Items and services furnished on  
16 an outpatient basis and outside any net-  
17 work of providers established or recognized  
18 under such plan or coverage.

19 “(D) TREATMENT LIMIT DEFINED.—For  
20 purposes of this paragraph, the term ‘treatment  
21 limit’ means, with respect to a plan or coverage,  
22 limitation on the frequency of treatment, num-  
23 ber of visits or days of coverage, or other simi-  
24 lar limit on the duration or scope of treatment  
25 under the plan or coverage.

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

8           “(4) BENEFICIARY FINANCIAL REQUIRE-  
9           MENTS.—

10           “(A) NO BENEFICIARY FINANCIAL RE-  
11           QUIREMENT.—If the plan or coverage does not  
12           include a beneficiary financial requirement (as  
13           defined in subparagraph (C)) on substantially  
14           all medical and surgical benefits within a cat-  
15           egory of items and services (specified in para-  
16           graph (3)(C)), the plan or coverage may not im-  
17           pose such a beneficiary financial requirement on  
18           mental health and substance-related disorder  
19           benefits for items and services within such cat-  
20           egory.

21           “(B) BENEFICIARY FINANCIAL REQUIRE-  
22           MENT.—

23           “(i) TREATMENT OF DEDUCTIBLES,  
24           OUT-OF-POCKET LIMITS, AND SIMILAR FI-  
25           NANCIAL REQUIREMENTS.—If the plan or

1 coverage includes a deductible, a limitation  
2 on out-of-pocket expenses, or similar bene-  
3 ficiary financial requirement that does not  
4 apply separately to individual items and  
5 services on substantially all medical and  
6 surgical benefits within a category of items  
7 and services, the plan or coverage shall  
8 apply such requirement (or, if there is  
9 more than one such requirement for such  
10 category of items and services, the pre-  
11 dominant requirement for such category)  
12 both to medical and surgical benefits with-  
13 in such category and to mental health and  
14 substance-related disorder benefits within  
15 such category and shall not distinguish in  
16 the application of such requirement be-  
17 tween such medical and surgical benefits  
18 and such mental health and substance-re-  
19 lated disorder benefits.

20 “(ii) OTHER FINANCIAL REQUIRE-  
21 MENTS.—If the plan or coverage includes a  
22 beneficiary financial requirement not de-  
23 scribed in clause (i) on substantially all  
24 medical and surgical benefits within a cat-  
25 egory of items and services, the plan or

1 coverage may not impose such financial re-  
2 quirement on mental health and substance-  
3 related disorder benefits for items and  
4 services within such category in a way that  
5 is more costly to the participant or bene-  
6 ficiary than the predominant beneficiary fi-  
7 nancial requirement applicable to medical  
8 and surgical benefits for items and services  
9 within such category.

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

21 (2) in subsection (b)—

22 (A) by striking “construed—” and all that  
23 follows through “(1) as requiring” and insert-  
24 ing “construed as requiring”;

1 (B) by striking “; or” and inserting a pe-  
2 riod; and

3 (C) by striking paragraph (2).

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

7 (1) by striking “mental health benefits” and in-  
8 serting “mental health and substance-related dis-  
9 order benefits” each place it appears; and

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

11 (A) by striking “MENTAL HEALTH BENE-  
12 FITS” and inserting “MENTAL HEALTH AND  
13 SUBSTANCE-RELATED DISORDER BENEFITS”;

14 (B) by striking “benefits with respect to  
15 mental health services” and inserting “benefits  
16 with respect to services for mental health condi-  
17 tions or substance-related disorders”; and

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

21 (c) AVAILABILITY OF PLAN INFORMATION ABOUT  
22 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of  
23 such section, as amended by subsection (a)(1), is further  
24 amended by adding at the end the following new para-  
25 graph:

1           “(5) AVAILABILITY OF PLAN INFORMATION.—

2           The criteria for medical necessity determinations  
 3           made under the plan with respect to mental health  
 4           and substance-related disorder benefits (or the  
 5           health insurance coverage offered in connection with  
 6           the plan with respect to such benefits) shall be made  
 7           available by the plan administrator (or the health in-  
 8           surance issuer offering such coverage) to any cur-  
 9           rent or potential participant, beneficiary, or con-  
 10          tracting provider upon request. The reason for any  
 11          denial under the plan (or coverage) of reimburse-  
 12          ment or payment for services with respect to mental  
 13          health and substance-related disorder benefits in the  
 14          case of any participant or beneficiary shall, upon re-  
 15          quest, be made available by the plan administrator  
 16          (or the health insurance issuer offering such cov-  
 17          erage) to the participant or beneficiary.”.

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

21                 “(6) MINIMUM SCOPE OF COVERAGE AND EQ-  
 22                 UNITY IN OUT-OF-NETWORK BENEFITS.—

23                         “(A) MINIMUM SCOPE OF MENTAL  
 24                         HEALTH AND SUBSTANCE-RELATED DISORDER  
 25                         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

1 such category furnished outside any net-  
2 work of providers established or recognized  
3 under such plan or coverage in accordance  
4 with the requirements of this section.

5 “(ii) CATEGORIES OF ITEMS AND  
6 SERVICES.—For purposes of clause (i),  
7 there shall be the following three categories  
8 of items and services for benefits, whether  
9 medical and surgical benefits or mental  
10 health and substance-related disorder bene-  
11 fits, and all medical and surgical benefits  
12 and all mental health and substance-re-  
13 lated disorder benefits shall be classified  
14 into one of the following categories:

15 “(I) EMERGENCY.—Items and  
16 services, whether furnished on an in-  
17 patient or outpatient basis, required  
18 for the treatment of an emergency  
19 medical condition (including an emer-  
20 gency condition relating to mental  
21 health and substance-related dis-  
22 orders).

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

1                   “(III) OUTPATIENT.—Items and  
2                   services not described in subclause (I)  
3                   furnished on an outpatient basis.”.

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

7                   “(2) INCREASED COST EXEMPTION.—

8                   “(A) IN GENERAL.—With respect to a  
9                   group health plan (or health insurance coverage  
10                  offered in connection with such a plan), if the  
11                  application of this section to such plan (or cov-  
12                  erage) results in an increase for the plan year  
13                  involved of the actual total costs of coverage  
14                  with respect to medical and surgical benefits  
15                  and mental health and substance-related dis-  
16                  order benefits under the plan (as determined  
17                  and certified under subparagraph (C)) by an  
18                  amount that exceeds the applicable percentage  
19                  described in subparagraph (B) of the actual  
20                  total plan costs, the provisions of this section  
21                  shall not apply to such plan (or coverage) dur-  
22                  ing the following plan year, and such exemption  
23                  shall apply to the plan (or coverage) for 1 plan  
24                  year.

1           “(B) APPLICABLE PERCENTAGE.—With re-  
2           spect to a plan (or coverage), the applicable  
3           percentage described in this paragraph shall  
4           be—

5                   “(i) 2 percent in the case of the first  
6                   plan year which begins after the date of  
7                   the enactment of the Paul Wellstone Men-  
8                   tal Health and Addiction Equity Act of  
9                   2007; and

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

12           “(C) DETERMINATIONS BY ACTUARIES.—  
13           Determinations as to increases in actual costs  
14           under a plan (or coverage) for purposes of this  
15           subsection shall be made by a qualified actuary  
16           who is a member in good standing of the Amer-  
17           ican Academy of Actuaries. Such determina-  
18           tions shall be certified by the actuary and be  
19           made available to the general public.

20           “(D) 6-MONTH DETERMINATIONS.—If a  
21           group health plan (or a health insurance issuer  
22           offering coverage in connection with such a  
23           plan) seeks an exemption under this paragraph,  
24           determinations under subparagraph (A) shall be  
25           made after such plan (or coverage) has com-

1           plied with this section for the first 6 months of  
2           the plan year involved.

3                   “(E) NOTIFICATION.—A group health plan  
4           under this part shall comply with the notice re-  
5           quirement under section 712(c)(2)(E) of the  
6           Employee Retirement Income Security Act of  
7           1974 with respect to the a modification of men-  
8           tal health and substance-related disorder bene-  
9           fits as permitted under this paragraph as if  
10          such section applied to such plan.”.

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

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

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

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

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

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

1           “(1) IN GENERAL.—Nothing in this section  
 2           shall be construed to preempt any State law that  
 3           provides greater consumer protections, benefits,  
 4           methods of access to benefits, rights or remedies  
 5           that are greater than the protections, benefits, meth-  
 6           ods of access to benefits, rights or remedies provided  
 7           under this section.

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

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

13          **“SEC. 2705. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**  
 14                  **RELATED DISORDER BENEFITS.”**

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

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

20          (a) EXTENSION OF PARITY TO TREATMENT LIMITS  
 21          AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section  
 22          9812 of the Internal Revenue Code of 1986 is amended—

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

25                  “(3) TREATMENT LIMITS.—

1           “(A) NO TREATMENT LIMIT.—If the plan  
2           does not include a treatment limit (as defined  
3           in subparagraph (D)) on substantially all med-  
4           ical and surgical benefits in any category of  
5           items or services (specified in subparagraph  
6           (C)), the plan may not impose any treatment  
7           limit on mental health and substance-related  
8           disorder benefits that are classified in the same  
9           category of items or services.

10           “(B) TREATMENT LIMIT.—If the plan in-  
11           cludes a treatment limit on substantially all  
12           medical and surgical benefits in any category of  
13           items or services, the plan may not impose such  
14           a treatment limit on mental health and sub-  
15           stance-related disorder benefits for items and  
16           services within such category that are more re-  
17           strictive than the predominant treatment limit  
18           that is applicable to medical and surgical bene-  
19           fits for items and services within such category.

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

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

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

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

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

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



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

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

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

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

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

1           nancial requirement on mental health and sub-  
2           stance-related disorder benefits for items and  
3           services within such category.

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

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

1 and such mental health and substance-re-  
2 lated disorder benefits.

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

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

1 does not include the application of any aggregate  
2 lifetime limit or annual limit.”; and

3 (2) in subsection (b)—

4 (A) by striking “construed—” and all that  
5 follows through “(1) as requiring” and inserting  
6 “construed as requiring”;

7 (B) by striking “; or” and inserting a period;  
8 and

9 (C) by striking paragraph (2).

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

13 (1) by striking “mental health benefits” and inserting  
14 “mental health and substance-related disorder  
15 benefits” each place it appears; and

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

17 (A) by striking “MENTAL HEALTH BENEFITS” in the heading and inserting “MENTAL  
18 HEALTH AND SUBSTANCE-RELATED DISORDER  
19 BENEFITS”;

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

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

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

9 “(5) AVAILABILITY OF PLAN INFORMATION.—  
10 The criteria for medical necessity determinations  
11 made under the plan with respect to mental health  
12 and substance-related disorder benefits shall be  
13 made available by the plan administrator to any cur-  
14 rent or potential participant, beneficiary, or con-  
15 tracting provider upon request. The reason for any  
16 denial under the plan of reimbursement or payment  
17 for services with respect to mental health and sub-  
18 stance-related disorder benefits in the case of any  
19 participant or beneficiary shall, upon request, be  
20 made available by the plan administrator to the par-  
21 ticipant or beneficiary.”.

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

1           “(6) MINIMUM SCOPE OF COVERAGE AND EQ-  
2           UNITY IN OUT-OF-NETWORK BENEFITS.—

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

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

19                 “(i) IN GENERAL.—In the case of a  
20                 plan that provides both medical and sur-  
21                 gical benefits and mental health and sub-  
22                 stance-related disorder benefits, if medical  
23                 and surgical benefits are provided for sub-  
24                 stantially all items and services in a cat-  
25                 egory specified in clause (ii) furnished out-

1 side any network of providers established  
2 or recognized under such plan or coverage,  
3 the mental health and substance-related  
4 disorder benefits shall also be provided for  
5 items and services in such category fur-  
6 nished outside any network of providers es-  
7 tablished or recognized under such plan in  
8 accordance with the requirements of this  
9 section.

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

20 “(I) EMERGENCY.—Items and  
21 services, whether furnished on an in-  
22 patient or outpatient basis, required  
23 for the treatment of an emergency  
24 medical condition (including an emer-  
25 gency condition relating to mental

1 health and substance-related dis-  
2 orders).

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

6 “(III) OUTPATIENT.—Items and  
7 services not described in subclause (I)  
8 furnished on an outpatient basis.”.

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

12 “(2) INCREASED COST EXEMPTION.—

13 “(A) IN GENERAL.—With respect to a  
14 group health plan, if the application of this sec-  
15 tion to such plan results in an increase for the  
16 plan year involved of the actual total costs of  
17 coverage with respect to medical and surgical  
18 benefits and mental health and substance-re-  
19 lated disorder benefits under the plan (as deter-  
20 mined and certified under subparagraph (C)) by  
21 an amount that exceeds the applicable percent-  
22 age described in subparagraph (B) of the actual  
23 total plan costs, the provisions of this section  
24 shall not apply to such plan during the fol-



1           lowing plan year, and such exemption shall  
2           apply to the plan for 1 plan year.

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

6                   “(i) 2 percent in the case of the first  
7                   plan year which begins after the date of  
8                   the enactment of the Paul Wellstone Men-  
9                   tal Health and Addiction Equity Act of  
10                  2007; and

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

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

21           “(D) 6-MONTH DETERMINATIONS.—If a  
22           group health plan seeks an exemption under  
23           this paragraph, determinations under subpara-  
24           graph (A) shall be made after such plan has

1           complied with this section for the first 6  
2           months of the plan year involved.”.

3           (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-  
4 ERS.—Subsection (c)(1) of such section is amended to  
5 read as follows:

6           “(1) SMALL EMPLOYER EXEMPTION.—

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

10          “(B) SMALL EMPLOYER.—For purposes of  
11          subparagraph (A), the term ‘small employer’  
12          means, with respect to a calendar year and a  
13          plan year, an employer who employed an aver-  
14          age of at least 2 (or 1 in the case of an em-  
15          ployer residing in a State that permits small  
16          groups to include a single individual) but not  
17          more than 50 employees on business days dur-  
18          ing the preceding calendar year. For purposes  
19          of the preceding sentence, all persons treated as  
20          a single employer under subsection (b), (c),  
21          (m), or (o) of section 414 shall be treated as 1  
22          employer and rules similar to rules of subpara-  
23          graphs (B) and (C) of section 4980D(d)(2)  
24          shall apply.”.

1 (g) ELIMINATION OF SUNSET PROVISION.—Such sec-  
 2 tion is amended by striking subsection (f).

3 (h) CONFORMING AMENDMENTS TO HEADING.—

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

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

8 (2) CLERICAL AMENDMENT.—The table of sec-  
 9 tions for subchapter B of chapter 100 of the Inter-  
 10 nal Revenue Code of 1986 is amended by striking  
 11 the item relating to section 9812 and inserting the  
 12 following new item:

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

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

16 **SEC. 5. GOVERNMENT ACCOUNTABILITY OFFICE STUDIES  
 17 AND REPORTS.**

18 (a) IMPLEMENTATION OF ACT.—

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

23 (A) the cost of health insurance coverage;

1 (B) access to health insurance coverage  
2 (including the availability of in-network pro-  
3 viders);

4 (C) the quality of health care;

5 (D) Medicare, Medicaid, and State and  
6 local mental health and substance abuse treat-  
7 ment spending;

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

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

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

24 (H) other matters as determined appro-  
25 priate by the Comptroller General.

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

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

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

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