

School, New York, NY; Michael Seigel, Professor, University of Florida Levin College of Law, Gainesville, FL; and Andrew Weissmann, Partner, Jenner & Block, New York, NY.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. AKAKA. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on September 18, 2007, at 2:30 p.m., to hold a closed business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

MENTAL HEALTH PARITY ACT OF 2007

Mr. REID. I ask unanimous consent that the Senate proceed to the consideration of Calendar No. 93, S. 558.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 558) to provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Health, Education, Labor and Pensions with an amendment to strike all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Mental Health Parity Act of 2007".

SEC. 2. MENTAL HEALTH PARITY.

(a) **AMENDMENTS OF ERISA.**—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 712 (29 U.S.C. 1185a) the following:

"SEC. 712A. MENTAL HEALTH PARITY.

"(a) **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 benefits, such plan or coverage shall ensure that—

"(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

"(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

"(b) **CLARIFICATIONS.**—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, such plan or coverage shall not be prohibited from—

"(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

"(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

"(3) applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

"(c) **IN- AND OUT-OF-NETWORK.**—

"(1) **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 benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

"(2) **CLARIFICATION.**—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate, reduce, or provide out-of-network coverage with respect to such plan (or coverage).

"(d) **SMALL EMPLOYER EXEMPTION.**—

"(1) **IN GENERAL.**—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 any 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.

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

"(A) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.**—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(B) **EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.**—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

"(e) **COST EXEMPTION.**—

"(1) **IN GENERAL.**—With respect to a group health plan (or health insurance coverage offered in connections 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 benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) 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. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

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

"(A) 2 percent in the case of the first plan year in which this section is applied; and

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

"(3) **DETERMINATIONS BY ACTUARIES.**—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section 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.

"(4) **6-MONTH DETERMINATIONS.**—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

"(5) **NOTIFICATION.**—An election to modify coverage of mental health benefits as permitted under this subsection 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) **RULE OF CONSTRUCTION.**—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

"(g) **MENTAL HEALTH BENEFITS.**—In this section, the term 'mental health benefits' means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage."

(b) **PUBLIC HEALTH SERVICE ACT.**—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by inserting after section 2705 (42 U.S.C. 300gg-5) the following:

"SEC. 2705A. MENTAL HEALTH PARITY.

"(a) **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 benefits, such plan or coverage shall ensure that—

"(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

"(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

"(b) **CLARIFICATIONS.**—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, such plan or coverage shall not be prohibited from—

"(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

"(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

“(3) be prohibited from applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

“(c) IN- AND OUT-OF-NETWORK.—

“(1) 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 benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits.

“(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate, reduce, or provide out-of-network coverage with respect to such plan (or coverage).

“(d) SMALL EMPLOYER EXEMPTION.—

“(1) IN GENERAL.—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 any 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.

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

“(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

“(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

“(e) COST EXEMPTION.—

“(1) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connections 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 benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) 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. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

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

“(A) 2 percent in the case of the first plan year in which this section is applied; and

“(B) 1 percent in the case of each subsequent plan year.

“(3) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section 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.

“(4) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

“(5) NOTIFICATION.—An election to modify coverage of mental health benefits as permitted under this subsection 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) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

“(g) MENTAL HEALTH BENEFITS.—In this section, the term ‘mental health benefits’ means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage, and when applicable as may be defined under State law when applicable to health insurance coverage offered in connection with a group health plan.”

SEC. 3. EFFECTIVE DATE.

(a) IN GENERAL.—The provisions of this Act shall apply to group health plans (or health insurance coverage offered in connection with such plans) beginning in the first plan year that begins on or after January 1 of the first calendar year that begins more than 1 year after the date of the enactment of this Act.

(b) TERMINATION OF CERTAIN PROVISIONS.—

(1) ERISA.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended by striking subsection (f) and inserting the following:

“(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.”

(2) PHSA.—Section 2705 of the Public Health Service Act (42 U.S.C. 300gg-5) is amended by striking subsection (f) and inserting the following:

“(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.”

SEC. 4. SPECIAL PREEMPTION RULE.

(a) ERISA PREEMPTION.—Section 731 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191) is amended—

(1) by redesignating subsections (c) and (d) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (b), the following:

“(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

“(1) IN GENERAL.—Notwithstanding any provision of section 514 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provision of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 712A.

“(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 712A(d)).”

(b) PHSA PREEMPTION.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg-23) is amended—

(1) by redesignating subsections (c) and (d) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (b), the following:

“(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

“(1) IN GENERAL.—Notwithstanding any provision of section 514 of the Employee Retirement Income Security Act of 1974 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provisions of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 2705A.

“(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 2705A(d)).”

(c) EFFECTIVE DATE.—The provisions of this section shall take effect with respect to a State, on the date on which the provisions of section 2 apply with respect to group health plans and health insurance coverage offered in connection with group health plans.

SEC. 5. FEDERAL ADMINISTRATIVE RESPONSIBILITIES.

(a) GROUP HEALTH PLAN OMBUDSMAN.—

(1) DEPARTMENT OF LABOR.—The Secretary of Labor shall designate an individual within the Department of Labor to serve as the group health plan ombudsman for the Department. Such ombudsman shall serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning coverage of mental health services under group health plans in accordance with this Act.

(2) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services shall designate an individual within the Department of Health and Human Services to serve as the group health plan ombudsman for the Department. Such ombudsman shall serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning coverage of mental health services under health insurance coverage issued in connection with group health plans in accordance with this Act.

(b) AUDITS.—The Secretary of Labor and the Secretary of Health and Human Services shall each provide for the conduct of random audits of group health plans (and health insurance coverage offered in connection with such plans) to ensure that such plans are in compliance with this Act (and the amendments made by this Act).

(c) GOVERNMENT ACCOUNTABILITY OFFICE STUDY.—

(1) STUDY.—The Comptroller General shall conduct a study that evaluates the effect of the implementation of the amendments made by this Act on the cost of health insurance coverage, access to health insurance coverage (including the availability of in-network providers), the quality of health care, the impact on benefits and coverage for mental health and substance abuse, the impact of any additional cost or savings to the plan, the impact on out-of-network coverage for mental health benefits (including substance abuse treatment), the impact on State mental health benefit mandate laws, other impact on the business community and the Federal Government, and other issues 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 Congress a report containing the results of the study conducted under paragraph (1).

(d) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor and the Secretary of Health and Human Services shall jointly promulgate final regulations to carry out this Act.

Mr. KENNEDY. Mr. President, today is a landmark day in our nation's struggle to achieve access to mental health services for all Americans. The Mental Health Parity Act of 2007 reflects a major agreement by the mental health community, business leaders, and the insurance industry to guarantee that persons with mental health needs receive fair and equitable health insurance. Its passage will mean dramatic new help for 113 million Americans who today are without mental health care and treatment.

Access to such care and treatment is one of the most important and neglected civil rights issues facing the nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society. They have been forced to pay more for the services they need and to worry about their job security if their employer learns of their condition. Sadly, in America today, patients with biochemical problems in their livers receive better care and greater compassion than patients with biochemical problems in their brains.

This bill will help end such unacceptable discrimination. As we have seen in the recent bipartisan CHIP legislation, no one questions the need for affordable treatment of physical illnesses, but those who suffer from mental illnesses face serious barriers in obtaining the care they need at a cost they can afford.

Like those suffering from physical illnesses, persons with mental disorders deserve the opportunity for quality care. The failure to obtain treatment can mean years of shattered dreams, unfulfilled potential and broken lives.

The need is clear. One in five Americans will suffer some form of mental illness this year, but only a third of them will receive treatment. Millions of our fellow citizens are unnecessarily enduring the pain and sadness of seeing a family member, friend, or loved one suffer illnesses that seize the mind and break the spirit.

Battling mental illness is a difficult process, but discrimination against persons with such illnesses is especially cruel, since the success rates for treatment often equal or surpass those for physical conditions. According to the National Institute of Mental Health, clinical depression treatment can be 70 percent successful, and treatment for schizophrenia can be 60 percent successful.

Eleven years ago, a bipartisan majority in Congress approved the original Mental Health Parity Act. That legislation was an important first step in bringing attention to discriminatory practices against the mentally ill, but it did little to correct the injustices that so many Americans continue to face. This bill takes the actions needed to end the long-standing discrimination against persons with mental illness.

Over the years we have heard compelling testimony from experts, activists,

and patients about the need to equalize coverage of physical and mental illnesses. Some of the most forceful testimony came several years ago from Lisa Cohen, a hardworking American from New Jersey, who suffers from both physical and mental illnesses, and is forced to pay exorbitant costs for treating her mental disorder, while paying very little for her physical disorder. Lisa is typical of millions of Americans for whom the burden of mental illness is compounded by the burden of unfair discrimination.

No Americans should be denied equal treatment for an illness because it involves the brain instead of the heart, the lungs, or other parts of their body. Mental health parity is a good investment for the Nation. The costs from lost worker productivity and extra physical care outweigh the costs of implementing parity for mental health treatment.

Study after study has shown that parity makes good financial sense. Mental illness imposes a huge financial burden on the Nation. It costs us \$300 billion each year in treatment expenses, lost worker productivity, and crime. This country can afford mental health parity. What we can't afford is to continue denying persons with mental disorders the care they need.

But equal treatment of those affected by mental illness is not just an insurance issue. It is a civil rights issue. At its heart, mental health parity is a question of simple justice.

Today is a turning point. We are finally moving toward ending this shameful form of discrimination in our society—discrimination against persons with mental illness. This bill is a true commitment by the insurance industry, business industry and the mental health community to bring fairness and dignity to the millions of Americans who have been second class patients for too long.

The 1996 act was an important step towards ending health insurance discrimination against mental illness. This bill takes another large step to close the loopholes that remain.

We would not be here without the strong commitment and skillful determination of the late Senator Paul Wellstone and Senator PETE DOMENICI. They deserve immense credit for their bipartisan leadership on mental health parity.

I also commend the staff, both Democrat and Republican, who worked so long and hard on this legislation. I particularly thank Carolyn Gluck of Senator REID's office and all the Democratic staff who worked in recent weeks to help us produce the bill we have today.

I also commend Ed Hild of Senator DOMENICI's staff and Andrew Patzman of Senator ENZI's staff for the many hours they spent with my staff to negotiate the bill.

On my staff, I especially commend several who worked so long and hard and well on this legislation—Michael

Myers, Carmel Martin, Kelsey Phipps, Daniel Dawes, Jennie Fay, Ches Garrison, and above all Connie Garner, whose passion, counsel and commitment I value so highly on this and many other issues. Without her dedicated guidance, we would not be at this important threshold today.

My hope is that as we improve access to mental health services for all Americans, we will also help end the stigma and discrimination against those with mental illness. Mental illnesses are treatable and curable, and it is high time to bring relief to those who suffer from them.

Mr. President, I yield the floor.

Mr. ENZI. Mr. President, I rise to join my colleagues and sponsors of this legislation, Senators DOMENICI and KENNEDY, for their long and tireless work bringing us to passage of this bill tonight.

This legislation is literally years, if not decades in the making, and reflects countless hours of sweat and negotiation.

With much effort and indispensable help, we managed to bring together long-opposed advocates from the mental health advocacy, provider, employer, and insurance communities around a solid, responsible, bipartisan, and long-overdue bill.

Passage of this bill is a beacon example of what can be accomplished when people roll up their sleeves and work together in a bipartisan way.

This legislation will bring fairness and relief to millions of Americans suffering from mental illness. The road is not yet over, but tonight is a tremendous step forward.

Mr. REID. Mr. President, Passage of the Mental Health Parity Act of 2007 is an important victory for individuals who are affected by mental illnesses. Over a decade has passed since we enacted the landmark 1996 mental health parity law that was championed by my good friend, the late Senator Paul Wellstone, and Senator DOMENICI. Before his untimely death, Paul Wellstone was a tireless and eloquent advocate for legislation that would strengthen the 1996 law and achieve full parity in coverage between mental and physical illnesses.

The Mental Health Parity Act of 2007 is the culmination of many years of work to build on and strengthen the 1996 Mental Health Parity Act. It is a good compromise that will ensure that plans covering mental health services cannot provide different financial requirements or treatment limitations than they would for medical or surgical benefits. This legislation is long overdue and I will continue to work to ensure it is enacted as soon as possible.

Mr. DODD. Mr. President, I rise in support of S. 558, the Mental Health Parity Act of 2007. After many months of negotiations, I am pleased to call myself a strong supporter of this legislation. I thank the Chairman of the Health, Education, Labor and pensions Committee and the senior Senator

from New Mexico for working with me and congratulate them on passage of S. 558. They and their staff have worked long hours to craft this compromise bill. Supporters of mental health parity, old and new, should commend the leadership of Senators KENNEDY and DOMENICI for their years of commitment and struggle to pass expanded Federal mental health parity legislation.

Millions of Americans are affected by mental illness. Each year, more than 50 million American adults will suffer from a mental disorder. All of us know a friend, a relative, a neighbor, a colleague whose life has been touched by mental illness, either their own or the illness of a loved one. Yet despite the compelling need, under many health plans, mental health benefits are much more limited than benefits for medical or surgical care. Even though a range of effective treatments exist for almost all mental disorders, those suffering from mental illness often face increased barriers to care and the stigma that underlies discriminatory practices in how we treat mental illness. These are the individuals that have insurance. It can only be worse for those without insurance. Mental health must not take a backseat to other health conditions.

My own State of Connecticut recognized the disparity between insurance coverage for physical and mental illness and made significant steps to address it by enacting strong mental health parity and consumer protection laws. These laws far exceed what exists currently at the Federal level and I believe the bill being passed by the Senate today will allow my State to maintain those strong laws in the future.

I was an original cosponsor of the original mental health parity bill in 1996 along with Senator DOMENICI and the late Senator Wellstone and have been a strong supporter of efforts to strengthen that bill since it was signed into law. But the legislation the HELP Committee marked up last February was different from what our late colleague Paul championed for so many years. The legislation our committee marked up contained preemption language which was broader in scope than what was in Federal mental health parity bills in the past.

For that reason, I offered amendments during that markup to address preemption in a way I believed would have taken a major step toward protecting State insurance laws and ensuring that we do no harm to State-based consumer protections through passage of Federal mental health parity. At that markup, I voiced concerns about the impact the bill would have on States like Connecticut who have strong mental health parity laws, strong consumer protection laws, and strong benefit mandate laws.

As a result of my continued concerns about the impact this bill would have on the residents of my State, I withheld cosponsorship of the legislation

until the issues surrounding preemption could be resolved. Due to the hard work and dedication of members on both sides of the aisle, my concerns have been addressed and I can now support the legislation.

Specifically, the bill being passed today removed the broad preemption language entirely. The bill now relies on the existing preemption of State law standard currently in the Employee Retirement Income Security Act and the Public Health Service Act, preserving States' laws relating to health insurance issuers. In many States, such issuers contract out the key insurance function of reviewing medical claims by their insureds to utilization review or medical management companies, which are licensed and regulated by the states. In fact, the legislation written by Chairman KENNEDY, called the Health Insurance Portability and Accountability Act, HIPAA, was an innovative approach to Federal health care reform that has worked well in setting a minimum standard of protections while allowing stronger State-based consumer protections. It is my understanding that the bill passed today will operate in a very similar manner.

I thank Senators KENNEDY and DOMENICI for entering into a colloquy with me to further clarify the intent of this legislation. They have been open and willing to working with me since the HELP Committee markup occurred to address the concerns I had with this legislation. I would also like to acknowledge and thank the tremendous work and expertise of Mila Kofman, Associate Research Professor, Health Policy Institute, Georgetown University. She worked tirelessly to assist the members and staff through the complex issues of ERISA and preemption. From my own State of Connecticut, I would like to thank Kevin Lembo, Victoria Veltri, and Richard Kehoe who worked closely with my staff to ensure that Connecticut's strong mental health parity laws would be protected under this legislation.

The bill we are passing today will not only mean new Federal protections for people in self-insured ERISA plans, but it will also protect workers and families in States with insurance laws that are stronger than the Federal ones by allowing those State laws to remain in effect. It reflects months and years of hard work and compromise. It is a victory for patients who need coverage for mental health services and I am pleased to stand in support of this legislation.

Mr. DOMENICI. Mr. President, I want to start by thanking my colleagues, Senators KENNEDY and ENZI, for all of their work and dedication on the Mental Health Parity Act of 2007. We would not be here this evening without them and a whole host of others both in and out of the Senate.

Simply put, our legislation will ensure individuals with a mental illness have parity between mental health

coverage and medical and surgical coverage. No longer will people with a mental illness have their mental health coverage treated differently than their coverage for other illnesses. That means parity between the coverage of mental illnesses and other medical conditions like cancer, heart disease, and diabetes.

No longer will people be treated differently only because they suffer from a mental illness, and that means 113 million people in group health plans will benefit from our bill. We are here after years of hard work. We have worked with the mental health community and the business and insurance groups to carefully craft a compromise bill.

No longer will a more restrictive standard be applied to mental health coverage and another more lenient standard be applied to medical and surgical coverage. What we are doing is a matter of simple fairness. I believe that becomes even more important when you consider the following: 26 percent of American adults, or nearly 58 million people, suffer from a diagnosable mental disorder each year, and 6 percent of those adults suffer from a serious mental illness. More than 30,000 people commit suicide each year in the United States, and 16 percent of all inmates in State and local jails suffer from a mental illness.

I would like to take a minute to talk about what we are doing with the passage of the Mental Health Parity Act of 2007. The bill provides mental health parity for about 113 million Americans who work for employers with 50 or more employees, ensures that 98 percent of businesses which provide a mental health benefit do so in a manner that is no more restrictive than the coverage of medical and surgical benefits, and ensures health plans do not place more restrictive conditions on mental health coverage than on medical and surgical coverage. The bill accomplishes this by providing parity for financial requirements like deductibles, copayments, and annual and lifetime limits and parity for treatment limitations, the number of covered hospital days and visits.

Again, I want to thank everyone for their extraordinary efforts that have allowed us to achieve Senate passage of the Mental Health Parity Act of 2007.

Mr. DURBIN. Mr. President, today the Senate takes a long overdue step in the right direction for the health of all Americans. The passage of the Mental Health Parity Act of 2007 recognizes the millions of people living with a mental illness and the millions of friends, family members, and communities who support them.

Mental health parity legislation simply calls for health plans to provide comparable levels of coverage for mental health services as are provided for traditional medical services. It doesn't sound like a radical proposal, yet it has taken years to move this legislation through the Senate.

We have made progress, though, and much of the leadership on this issue has been provided by Senator KENNEDY and Senator DOMENICI in recent years. We started in 1992, when my good friend, the late Senator Paul Wellstone, and Senator PETE DOMENICI introduced the Mental Health Parity Act to correct the unfair burden placed on American families living with mental illness without access to mental health services.

It took a while, but in 1996, the first mental health parity legislation was enacted into law. It wasn't a perfect bill. It fell far short of its goal in many respects, but it was a significant piece of legislation that acknowledged the longstanding bias against covering mental health services.

Based on what we did in 1996, current law requires insurers that offer mental health care to offer comparable benefit caps for mental health and physical health. Unfortunately, that left a loophole that has allowed the common practice in which insurers set higher deductibles, charge higher copays, and cover fewer services for mental health care. As a result, millions of Americans are left without affordable mental health treatment. What they are left with is the often crushing aftermath—loss of employment, poor school performance, poverty, and even suicide.

Every year since that 1996 law was enacted, the Senate has had a mental health parity bill to fix this problem, but to no avail. This year, for the first time in a decade, the Senate has passed a bill to address the loopholes in the mental health parity law. I commend Senators KENNEDY and DOMENICI for their dedication to seeing this through. I only wish that Paul Wellstone could have lived to see this day.

Paul Wellstone was a good friend of mine and an inspiration to me and to many others who served with him in the Chamber. Throughout his congressional career, Paul fought tirelessly for equal rights for all, regardless of their race, religion, socioeconomic status, or health status. He was a champion of many causes, but no cause was more dear, or more personal, to him than making sure that people with mental illness were treated fairly and with dignity.

Paul Wellstone was touched personally by mental illness. His older brother lived and struggle with mental illness most of his life. Paul believed that for his brother, and for all Americans, mental health was as important as physical health. Senator PETE DOMENICI, too, understands the importance of having access to mental health services. His daughter also has struggled with mental illness.

Fifteen years ago, Senators Wellstone and DOMENICI brought home a fact that is as true today as it was then—nearly everyone knows someone living with a mental illness. According to the National Institute of Mental Health, more than one in four adults in the United States—more than 57 mil-

lion adults—suffer from a diagnosable mental disorder in a given year. One in seventeen Americans suffers from a serious mental illness.

These two Senators were fiercely determined to end discrimination against people with mental illness. We all lost a spirited champion for mental health on October 25, 2002, when Paul Wellstone was in a fatal plane crash. But the fight for mental health parity has lived on. Senator KENNEDY quickly took up the fight, and he and Senator DOMENICI have resolutely worked to strengthen common ground and supporters who would bring us to this day, the day of Senate passage of the mental health parity bill.

Last year, the Senate passed a resolution I submitted that marked the fourth anniversary of Paul Wellstone's death. The resolution expresses the sense of the Senate that Congress should act "to provide for equal coverage of mental health benefits with respect to health insurance coverage"—in other words, pass mental health parity.

I am proud to note the Senate's action today. With the passage of the Mental Health Parity Act of 2007, we are assuring millions of Americans that mental illness deserves equal treatment as physical illness. We are telling millions of families that help is available and that they no longer have to feel excluded. And most importantly, we are opening doors to hope and closing doors to desperation.

We may not live in a perfect world but we are closer to a more perfect union. It is in the spirit of Paul Wellstone and—thanks to Senators KENNEDY and DOMENICI—the spirit of bipartisanship that we pass this historic piece of legislation. Senator Wellstone was quoted as saying:

I don't think politics has anything to do with left, right, or center. It has to do with trying to do right by the people.

Today, I think Paul would agree that the Senate has done right.

PREEMPTION AND PROTECTING STATE LAWS

Mr. DOMENICI. Mr. President, as someone who has worked to bring a greater understanding of mental illness and to end all forms of discrimination against people who suffer from a mental illness, I am pleased to report that the Senate has passed a monumental mental health parity bill that could bring hope and greater measure of fairness in mental health insurance care coverage to as many as 113 million Americans and nearly 500,000 New Mexicans. This legislation, the Mental Health Parity Act of 2007, builds on the 1996 Mental Health Parity law that I authored with the late Senator Paul Wellstone. It is supported by more than 230 organizations and has been a bipartisan effort from the beginning. I thank Senator KENNEDY, the chairman of the Health, Education, Labor and Pensions Committee, for his vision, his leadership and his support for this legislation.

Mr. KENNEDY. I thank the Senator from New Mexico for his tremendous

leadership on this bill. He has fought for this legislation for many years, and I am grateful for his commitment to getting this bill passed. This legislation represents the culmination of more than a year's negotiations involving lawmakers, mental health, insurance and business organizations to craft compromise legislation. During the markup of the bill last February, my colleague Senator DODD raised very important issues regarding the effects of the preemption language in the legislation. Since then, he was joined by several other Senators, attorneys general, and State insurance commissioners who have voiced concerns about unintended consequences of the bill. It was never the intent of the bill to harm or weaken State insurance laws but in response to concerns raised by several of my colleagues and insurance experts, the language pertaining to preemption was stricken from the legislation.

Mr. DODD. I thank the chairman of the HELP Committee and the distinguished senior Senator from New Mexico and congratulate them on passage of S. 558, the Mental Health Parity Act. They and their staff have worked long hours to craft this compromise bill, and I congratulate them on this victory for individuals with mental illness throughout the country. Supporters of mental health parity, old and new, should commend the leadership of Senators DOMENICI and KENNEDY for their years of commitment and struggle to pass Federal mental health parity legislation.

I was an original cosponsor of the original mental health parity bill in 1996, along with Senator DOMENICI and the late Senator Wellstone, and have been a strong supporter of efforts to strengthen that bill since it was signed into law. But, as my colleagues may know, the legislation the HELP Committee marked up last February which is now before the Senate is different from what our late colleague Paul championed for so many years. The legislation our committee marked up contained preemption language which was broader in scope than what was in Federal mental health parity bills in the past. For that reason, I filed amendments during that markup to address preemption in a way I believed would have taken a major step toward protecting State insurance laws and ensuring that we do no harm to State-based consumer protections through Federal mental health parity. At that markup, I voiced concerns about the impact the bill would have on States like Connecticut who have strong mental health parity laws, strong consumer protection laws, and strong benefit mandate laws.

As a result of my continued concerns about the impact this bill would have on the residents of my State, I withheld cosponsorship of the legislation until the issues surrounding preemption could be resolved. I am pleased to say that because of the hard work and

dedication of Members on both sides of the aisle, my concerns have been addressed and I can now support the legislation.

Mr. KENNEDY. I thank the senior Senator from Connecticut and appreciate his leadership on this issue. He raised a number of important issues during the consideration of this bill. I believe we have addressed those concerns in the legislation and I am pleased that he is now a strong supporter of the legislation.

Mr. DODD. The bill passing the Senate today relies on the existing preemption of State law standard currently in ERISA and the Public Health Service Act, preserving States laws relating to health insurance issuers. In many States, such issuers contract out the key insurance function of reviewing medical claims by their insurers to utilization review or medical management companies, which are licensed and regulated by the States. In fact, the legislation written by the Senator from Massachusetts, called HIPAA, was an innovative approach to Federal health care reform that has worked so well in setting a minimum standard of protections while allowing stronger State-based consumer protections. Is it the distinguished senior Senator from Massachusetts' belief that S. 558 preserves the States' ability to regulate such companies?

Mr. KENNEDY. Yes, nothing in this bill affects any State law or State regulation of any company or issuer who performs utilization review or other medical management services. The changes made to the preemption section of S. 558 mean that the current HIPAA standard would apply to this legislation, just like it applies to existing law passed in 1996. By using existing preemption language, we mean only the narrowest preemption of State laws. A minimum standard of Federal protection allows States to provide additional protection for their citizens. State laws designed to regulate medical management or utilization review to protect plan participants are not preempted under the bill because they do not "prevent the application" of the substantive provisions of this bill.

Mr. DODD. Is it also the understanding of the senior Senator from New Mexico that this legislation will not only mean new Federal protections for people in self-insured ERISA plans, but it will also protect workers and families in States with insurance laws that are stronger than the Federal ones by allowing those State laws to remain in effect?

Mr. DOMENICI. Yes, the senior Senator from Connecticut is correct.

Mr. DODD. I thank the Senator and want to thank the Senator from Massachusetts for allowing my concerns about preemption and protecting State laws to be heard in the committee and for working tirelessly with me to address those concerns. The bill we are passing reflects months and years of hard work and compromise, and I am

pleased to voice my strong support for S. 558. It is a victory for patients who need coverage for mental health services.

Mr. REID. I ask unanimous consent that the amendment at the desk be considered and agreed to; the committee-reported amendment, as amended, be agreed to; the motions to reconsider be laid upon the table, en bloc; the bill, as amended, be read three times and passed; the motion to reconsider be laid upon the table; and that any statements be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 2908) was agreed to.

(The amendment is printed in today's RECORD under "Text of Amendments.") The committee amendment in the nature of a substitute, as amended, was agreed to.

The bill (S. 558), as amended, was ordered to be engrossed for a third reading, was read the third time, and passed.

Mr. REID. Mr. President, I congratulate Senators KENNEDY, ENZI, and others who worked on this legislation for such a long time. They are to be commended. Senator Wellstone, I am sure, is smiling on us today.

ORDERS FOR WEDNESDAY, SEPTEMBER 19, 2007

Mr. REID. I ask unanimous consent that when the Senate completes its business today, it stand adjourned until 9:30 a.m. tomorrow; that on September 19, following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, and, following the time utilized by the two leaders, the Senate then resume consideration of H.R. 1585, the Defense Department authorization bill, and we proceed to 60 minutes of debate prior to a vote on the motion to invoke cloture on amendment No. 2022, with the time to be equally divided and controlled between the leaders or their designees; that upon the conclusion of the debate, the Senate proceed to vote on the motion to invoke cloture; that Members have until 10 a.m. to file any germane second-degree amendments to amendment No. 2022.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. REID. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 6:47 p.m., adjourned until Wednesday, September 19, 2007, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF DEFENSE

ANITA K. BLAIR, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF THE NAVY, VICE WILLIAM A. NAVAS, JR., RESIGNED.

DEPARTMENT OF VETERANS AFFAIRS

MICHAEL W. HAGER, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF VETERANS AFFAIRS (HUMAN RESOURCES AND MANAGEMENT), VICE ROBERT ALLEN PITTMAN, RESIGNED.

DEPARTMENT OF LABOR

KEITH HALL, OF VIRGINIA, TO BE COMMISSIONER OF LABOR STATISTICS, DEPARTMENT OF LABOR, FOR A TERM OF FOUR YEARS, VICE KATHLEEN P. UTGOFF, TERM EXPIRED.

IN THE COAST GUARD

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES COAST GUARD RESERVE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be rear admiral

REAR ADM. (LH) MICHAEL R. SEWARD, 0000

THE FOLLOWING NAMED OFFICERS OF THE COAST GUARD PERMANENT COMMISSIONED TEACHING STAFF FOR APPOINTMENT IN THE GRADE INDICATED IN THE UNITED STATES COAST GUARD UNDER TITLE 14, U.S.C., SECTION 188:

To be captain

JOSEPH E. VORBACH, 0000
RICHARD W. SANDERS, 0000

To be commander

DARRELL SINGLETERRY, 0000

To be lieutenant commander

THOMAS W. DENUCCI, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES COAST GUARD RESERVES UNDER TITLE 10, U.S.C., SECTION 12203:

To be captain

JEFFREY G. ANDERSON, 0000
MICHAEL A. CICALESE, 0000
MICHAEL D. COLLINS, 0000
DOUGLAS J. DAWSON, 0000
SERENA J. DIETRICH, 0000
DALE V. FERRIERE, 0000
DAVID M. GARDNER, 0000
DOUGLAS W. HEUGEL, 0000
BRIAN H. OFFORD, 0000
KEVIN J. OLD, 0000
CONRAD W. ZVARA, 0000

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES COAST GUARD UNDER TITLE 14, U.S.C., SECTION 271:

To be captain

CHRISTOPHER D. ALEXANDER, 0000
LATICIA J. ARGENTI, 0000
WEBSTER D. BALDING, 0000
MATTHEW T. BELL, 0000
MELISSA BERT, 0000
WYMAN W. BOUBOULIS, 0000
WYMAN W. BRIGGS, 0000
JAMES M. CASH, 0000
PAULINE F. COOK, 0000
THOMAS E. CRABS, 0000
JOHN T. DAVIS, 0000
SCOTT N. DECKER, 0000
JERRY N. DOHERTY, 0000
THOMAS H. FARRIS, 0000
JAMES O. FITTON, 0000
JOHN M. FITZGERALD, 0000
PAUL E. FRANKLIN, 0000
JOHN D. GALLAGHER, 0000
PETER W. GAUTIER, 0000
GLENN L. GEBELE, 0000
ANTHONY R. GENTILELLA, 0000
VERNE B. GIFFORD, 0000
NANCY R. GOODRIDGE, 0000
THOMAS C. HASTINGS, 0000
BEVERLY A. HAVLIK, 0000
WILLIAM G. HISHON, 0000
GWYN R. JOHNSON, 0000
ERIC C. JONES, 0000
WILLIAM G. KELLY, 0000
JOHN S. KENYON, 0000
JAMES L. KNIGHT, 0000
DONALD A. LACHANCE, 0000
ROGER R. LAFERRIERE, 0000
JOHN K. LITTLE, 0000
GORDON A. LOBEL, 0000
KEVIN E. LUNDAY, 0000
SEAN M. MAHONEY, 0000
DWIGHT T. MATHERS, 0000
STUART M. MERRILL, 0000
MICHAEL A. MOHN, 0000
FREDERICK G. MYER, 0000
JACK W. NIEMIEC, 0000
JOANNA M. NUNAN, 0000
SALVATORE C. PALMERI, 0000
JOHN J. PLUNKETT, 0000
ANTHONY POPIEL, 0000
RAYMOND W. PULVER, 0000
STEVEN J. REYNOLDS, 0000
MARK D. RIZZO, 0000
MATTHEW T. RUCKERT, 0000
JAMES W. SEBASTIAN, 0000