Spratt
Stark
Stearns
Stupak
Sullivan
Sutton
Tancredo
Tanner
Tauscher
Taylor
Terry
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Towns
Tsongas
Turner
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velázquez
Visclosky
Walberg
Walden (OR)
Walsh (NY)
Walz (MN)
Wamp
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch (VT)
Weldon (FL)
Weller
Westmoreland
Wexler
Whitfield (KY)
Wilson (NM)
Wilson (OH)
Wilson (SC)
Wittman (VA)
Wolf
Wu
Wynn
Yarmuth
Young (AK)
Young (FL)

NOT VOTING—16

Brown-Waite, Ginny
Conyers
Gonzalez
Gordon
Johnson, E. B.
Keller
Meek (FL)
Ortiz
Poe
Pryce (OH)
Rangel
Renzi
Rush
Schmidt
Sires
Woolsey

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that there are 2 minutes remaining in this vote.

□ 1628

So (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

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## PERSONAL EXPLANATION

Mr. CONYERS. Mr. Speaker, on March 5, 2008, I was unavoidably detained due to weather-related travel delays. The following list describes how I would have voted had I been in attendance this afternoon.

"Yea"—H.R. 4191, To redesignate Dayton Aviation Heritage National Historic Park in the State of Ohio as "Wright Brothers-Dunbar National Historic Park", and for other purposes.

"Yea"—H. Con. Res. 278, Supporting Taiwan's fourth direct and democratic presidential elections in March 2008.

"Present"—H. Res. 951, Condemning the ongoing Palestinian rocket attacks on Israeli civilians, and for other purposes.

"Yea"—On motion to consider the resolution H. Res. 1014, providing for the consideration of H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act.

"Yea"—On ordering the previous question on H. Res. 1014, providing for the consideration of H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act.

"Yea"—H. Res. 1014, Providing for the consideration of H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act.

"Yea"—H.R. 4774, To designate the facility of the United States Postal Service located at 10250 John Saunders Road in San Antonio, Texas, as the "Cyndi Taylor Krier Post Office Building".

"Yea"—H. Con. Res. 286, Expressing the sense of Congress that Earl Lloyd should be recognized and honored for breaking the color barrier and becoming the first African American to play in the National Basketball Association League 58 years ago.

## PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007

Mr. PALLONE. Mr. Speaker, pursuant to House Resolution 1014, I call up the bill (H.R. 1424) to amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans, and ask for its immediate consideration.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1424

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

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

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

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

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

''(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services (as specified in paragraph (3)(C)), the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

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

''(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term 'beneficiary financial requirement' includes, with respect to a plan or coverage, any deductible, coinsurance, co-payment,

other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan or coverage, but does not include the application of any aggregate lifetime limit or annual limit.''; and

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

''(E) NOTIFICATION.—An election to modify coverage of mental health and substance-related disorder benefits as permitted under this paragraph shall be treated as a material modification in the terms of the plan as described in section 102(a)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).''.

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

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

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

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

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

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

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

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

(i) CONFORMING AMENDMENTS TO HEADING.—

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

**''SEC. 712. Equity in mental health and substance-related disorder benefits.''.**

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

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

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

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

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

''(E) NOTIFICATION.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the

Employee Retirement Income Security Act of 1974 with respect to the a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.''.

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

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

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

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

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

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

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

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

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

**''SEC. 2705. Equity in mental health and substance-related disorder benefits.''.**

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

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

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

''(1) SMALL EMPLOYER EXEMPTION.—

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

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

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

(h) CONFORMING AMENDMENTS TO HEADING.—

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

**''SEC. 9812. Equity in mental health and substance-related disorder benefits.''.**

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

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

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

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

(a) IMPLEMENTATION OF ACT.—

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

(A) the cost of health insurance coverage;

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

(C) the quality of health care;

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

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

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

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

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

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

(b) BIANNUAL REPORT ON OBSTACLES IN OBTAINING COVERAGE.—Every two years, the Comptroller General shall submit to each House of the Congress a report on obstacles that individuals face in obtaining mental health and substance-related disorder care under their health plans.

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

The SPEAKER pro tempore. Pursuant to House Resolution 1014, in lieu of the amendments recommended by the Committees on Energy and Commerce, Ways and Means, and Education and Labor printed in the bill, the amendment in the nature of a substitute printed in House report 110–538 is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

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

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

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

Sec. 1. Short title; table of contents.
Sec. 2. Amendments to the Employee Retirement Income Security Act of 1974.
Sec. 3. Amendments to the Public Health Service Act relating to the group market.
Sec. 4. Amendments to the Internal Revenue Code of 1986.
Sec. 5. Medicaid drug rebate.
Sec. 6. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.
Sec. 7. Studies and reports.

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

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

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

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

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

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

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

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

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

''(iii) OUTPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished

on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

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

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

''(D) TREATMENT LIMIT DEFINED.—For purposes of this paragraph, the term 'treatment limit' means, with respect to a plan 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.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

''(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FINANCIAL REQUIREMENTS.—If the plan or coverage includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services (as specified in paragraph (3)(C)), the plan or coverage shall apply such requirement (or, if there is more than one such requirement for such category of items and services, the predominant requirement for such category) both to medical and surgical benefits within such category and to mental health and substance-related disorder benefits within such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

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

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

''(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

''(i) 2 percent in the case of the first plan year to which this paragraph applies; and

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

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

health insurance issuer, as the case may be) to the general public.

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

''(E) NOTIFICATION.—An election to modify coverage of mental health and substance-related disorder benefits as permitted under this paragraph shall be treated as a material modification in the terms of the plan as described in section 102(a) and notice of which shall be provided a reasonable period in advance of the change.

''(F) NOTIFICATION OF APPROPRIATE AGENCY.—

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

''(ii) REQUIREMENT.—A notification under clause (i) shall include—

''(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

''(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

''(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

''(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Department of Labor shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

''(I) a breakdown of States by the size and any type of employers submitting such notification; and

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

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

''(H) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan (or health insurance coverage offered in connection with such a plan) from complying with the provisions of this section notwithstanding that the plan or coverage is not required to comply with such provisions due to the application of subparagraph (A).''.

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

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

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

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

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

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

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

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

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

(i) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

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

(B) January 1, 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

or other similar limit on the duration or scope of treatment under the plan or coverage.

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

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

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

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

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

''(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

''(i) 2 percent in the case of the first plan year to which this paragraph applies; and

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

''(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this subsection shall be made in writing and prepared and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be made available by the plan administrator (or health insurance issuer, as the case may be) to the general public.

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

''(E) NOTIFICATION.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the Employee Retirement Income Security Act of 1974 with respect to a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.

''(F) NOTIFICATION OF APPROPRIATE AGENCY.—

''(i) IN GENERAL.—A group health plan that, based on a certification described under subparagraph (C), qualifies for an exemption

under this paragraph, and elects to implement the exemption, shall notify the Secretary of Health and Human Services of such election.

''(ii) REQUIREMENT.—A notification under clause (i) shall include—

''(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

''(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

''(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

''(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Secretary of Health and Human Services shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

''(I) a breakdown of States by the size and any type of employers submitting such notification; and

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

''(G) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan (or health insurance coverage offered in connection with such a plan) from complying with the provisions of this section notwithstanding that the plan or coverage is not required to comply with such provisions due to the application of subparagraph (A).''.

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

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

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

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

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

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

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

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

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

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

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

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

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

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

(B) January 1, 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

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

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

(2) in subsection (b)—

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

(B) by striking ''; or'' and inserting a period, and

(C) by striking paragraph (2).

(b) EXPANSION TO SUBSTANCE-RELATED DISORDER BENEFITS AND REVISION OF DEFINITION.—Section 9812 of such Code is further amended—

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

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

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

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

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

(c) AVAILABILITY OF PLAN INFORMATION ABOUT CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of section 9812 of such Code, as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

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

(d) MINIMUM BENEFIT REQUIREMENTS.—Subsection (a) of section 9812 of such Code is further amended by adding at the end the following new paragraph:

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

''(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan that provides any mental health or substance-related disorder benefits, the plan shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

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

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

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

(e) REVISION OF INCREASED COST EXEMPTION.—Paragraph (2) of section 9812(c) of such Code is amended to read as follows:

''(2) INCREASED COST EXEMPTION.—

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

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

''(i) 2 percent in the case of the first plan year to which this paragraph applies, and

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

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

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

''(E) NOTIFICATION OF APPROPRIATE AGENCY.—

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

''(ii) REQUIREMENT.—A notification under clause (i) shall include—

''(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

''(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

''(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

''(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Secretary of the Treasury shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

''(I) a breakdown of States by the size and any type of employers submitting such notification; and

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

''(F) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan from complying with the provisions of this section notwithstanding that the plan is not required to comply with such provisions due to the application of subparagraph (A).''.

(f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOYERS.—Paragraph (1) of section 9812(c) of such Code is amended to read as follows:

''(1) SMALL EMPLOYER EXEMPTION.—

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

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

(g) ELIMINATION OF SUNSET PROVISION.—Section 9812 of such Code is amended by striking subsection (f).

(h) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

(i) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

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

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of

the enactment of this Act, the amendments made by this section (other than subsection (g)) shall not apply to plan years beginning before the later of—

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

(B) January 1, 2009.

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

**SEC. 5. MEDICAID DRUG REBATE.**

Paragraph (1)(B)(i) of section 1927(c) of the Social Security Act (42 U.S.C. 1396r–8(c)) is amended—

(1) by striking ''and'' at the end of subclause (IV);

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2009, and after December 31, 2014,'' after ''December 31, 1995,''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(VI) after December 31, 2008, and before January 1, 2015, is 20.1 percent.''.

**SEC. 6. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.**

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

(3) by adding at the end the following new subsection:

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership on the date of enactment of this subsection; and

''(ii) a provider agreement under section 1866 in effect on such date of enactment.

''(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner and any other owners of the hospital; and

''(II) the nature and extent of all ownership interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

''(I) the ownership interest of such referring physician in the hospital; and

''(II) if applicable, any such ownership interest of the treating physician.

''(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(iv) The hospital discloses the fact that the hospital is partially owned by physicians—

''(I) on any public website for the hospital; and

''(II) in any public advertising for the hospital.

''(D) ENSURING BONA FIDE INVESTMENT.—

''(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

''(iv) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

''(v) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

''(vi) Investment returns are distributed to each investor in the hospital in an amount that is directly proportional to the investment of capital by such investor in the hospital.

''(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

''(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(I) the hospital discloses such fact to a patient; and

''(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

''(ii) The hospital has the capacity to—

''(I) provide assessment and initial treatment for patients; and

''(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community that the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is 18 months after the date of enactment of this subsection.

''(iv) REGULATIONS.—Not later than the date that is 18 months after the date of enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i).

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms and beds of the applicable hospital above the baseline number of operating rooms and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms and beds of the hospital after the application of the most recent increase under such an exception) by an amount determined appropriate by the Secretary.

''(ii) LIFETIME 50 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms and beds of an applicable hospital under clause (i) to the extent such increase would result in the number of operating rooms and beds of the applicable hospital exceeding 150 percent of the baseline number of operating rooms and beds of the applicable hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS AND BEDS.—In this paragraph, the term 'baseline number of operating rooms and beds' means the number of operating rooms and beds of the applicable hospital as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms and beds of an applicable hospital pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

''(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 200 percent of the percentage increase in the population growth of the United States during that period, as estimated by Bureau of the Census;

''(ii) whose annual percent of total inpatient admissions and outpatient visits that

represent inpatient admissions and outpatient visits under the program under title XIX is equal to or greater than the average percent with respect to such admissions and visits for all hospitals located in the State;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

''(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

''(v) in the case of a hospital located—

''(I) in a core-based statistical area, that is located in such an area in which the average bed occupancy rate in such area is greater than 80 percent; or

''(II) outside of a core-based statistical area, that is located in a State in which the average bed occupancy rate is greater than 80 percent.

''(F) PUBLICATION OF FINAL DECISIONS.—The Secretary shall publish final decisions with respect to applications under this paragraph in the Federal Register.

''(G) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

''(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

''(5) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term 'physician owner' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership interest in the hospital.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

(c) ADJUSTMENT TO PAQI FUND.—Section 1848(l)(2)(A)(i)(III) of the Social Security Act (42 U.S.C. 1395w-4(l)(2)(A)(i)(III)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), is amended by striking ''$4,960,000,000'' and inserting ''$5,120,000,000''.

**SEC. 7. STUDIES AND REPORTS.**

(a) IMPLEMENTATION OF ACT.—

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

(A) the cost of health insurance coverage;

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

(C) the quality of health care;

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

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

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

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

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

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

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

(c) DOL BIANNUAL REPORT ON ANY OBSTACLES IN OBTAINING COVERAGE.—Every two years, the Secretary of Labor, in consultation with the Secretaries of Health and Human Services and the Treasury, shall submit to the appropriate committees of each House of the Congress a report on obstacles, if any, that individuals face in obtaining mental health and substance-related disorder care under their health plans.

The SPEAKER pro tempore. Debate shall not exceed 2 hours, equally divided and controlled by the chairman and ranking minority member of the Committees on Energy and Commerce, Ways and Means, and Education and Labor.

The gentleman from New Jersey (Mr. PALLONE), the gentleman from Georgia (Mr. DEAL), the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. CAMP), the gentleman from California (Mr. GEORGE MILLER), and the gentleman from California (Mr. MCKEON) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to insert extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

I rise today to support the passage of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, a comprehensive bill which will establish full mental health and addiction care parity. My colleagues, Representative PATRICK KENNEDY and Representative JIM RAMSTAD, have worked exhaustively to complete the mission that Congress embarked upon more than 10 years ago through the passage of the Mental Health Parity Act of 1996. That 1996 act authorized for 5 years partial parity by mandating that the annual and lifetime dollar limit for mental health treatment under group health plans offering mental health coverage be no less than that for physical illnesses.

H.R. 1424, introduced by Representatives KENNEDY and RAMSTAD, will fully ensure equity in coverage for mental illness and substance abuse disorders by requiring that group health plans with mental health coverage offer that coverage without the imposition of discriminatory financial requirements or discriminatory treatment limitations. The bill also protects against discrimination by diagnosis and requires plans to cover all mental health and substance abuse disorders.

Mental illnesses are biologically based disorders, and there is no reason we should affirmatively provide protections to a student with depression or a young adult with schizophrenia, but not a child with autism or an elderly person with dementia. The bill also requires equality in out-of-network coverage. Again, a plan need not offer out-of-network coverage, but if it does for medical conditions, it should for mental illnesses as well. There are many good actors that already offer equity in care. However, some try and create a phantom network of providers, where doctors in the network have long waiting lists or are not appropriate to treat certain illnesses.

Mental disorders are the leading cause of disability in the United States for individuals between the ages of 15 and 44. But many health disorders are very treatable illnesses. H.R. 1424 would allow those individuals and families struggling to cope with the diverse array of illnesses which fall under the category of mental illness to have greater access to affordable care in order to alleviate the tremendous burden that these conditions can cause.

Furthermore, H.R. 1424 will help to allow individuals that have been disabled by mental health and addiction disorders to acquire the treatment that they need in order to once again become productive members of society.

Mr. Speaker, I strongly urge my colleagues to vote in favor of the passage of this important legislation which will ensure the equitable treatment of very serious diseases.

I reserve the balance of my time.

Mr. DEAL of Georgia. Mr. Speaker, I would yield myself such time as I may consume.

Mr. Speaker, I rise today in opposition to this legislation. It is unfortunate that the majority in the House refused to pursue a strategy that our colleagues in the other body found appropriate for this legislation. Legislating, as we know, means compromising, and our colleagues on the other side of the Capitol worked together to craft a consensus piece of mental health parity legislation.

As a supporter of the concept of mental health parity, it is disappointing to me that the House has instead decided to jeopardize the possibility of getting legislation on mental health parity this year by ignoring the broad consensus among Members and stakeholders which was developed in the Senate.

Mental illness affects tens of millions of Americans. According to the Surgeon General, approximately one in five Americans suffers adverse mental conditions during any given year. The impact from such illnesses on families can be devastating, and we must be doing more to improve access to mental health services. However, this bill before us today is not the correct approach.

At a time of climbing premiums and health insurance costs, it is strange to me that we would pursue a path which the CBO acknowledges will raise the price of health insurance. CBO also projected that H.R. 1424 would cause some to lose their health insurance benefits and some employers to terminate mental health benefits altogether. In the face of a growing uninsured population in this country, statements like these from CBO concern me. We must find a more balanced approach to this problem that protects access to health insurance and mental health benefits.

The bill's focus is also overly broad and includes coverage of some conditions that fall well short of diseases under most scientifically accepted definitions. Our legislation should focus on serious biologically based mental disorders like schizophrenia and bipolar disorder, not on jet lag and caffeine addiction, as this bill would include. Employers may be willing to provide coverage for serious mental disorders, but under this bill could decide to drop coverage of mental illness altogether because they cannot afford the scope of the DSM–IV, the Diagnostic and Statistical Manual of Mental Disorders. Surely, this is an unintended consequence we should all want to avoid.

It is also important to note that under the bill, no executive or congressional action would intercede between the decisions of the American Psychiatric Association in the creation of the DSM and future legal requirements with which employers and insurers must comply under penalty of Federal law. I have always been concerned that this represents a likely constitutional conflict under the delegations doctrine. The bill appears to leave any update of what qualifies as mental health conditions and, therefore, coverage under the bill to the American Psychiatric Association. There are no criteria for judicial review, required notice and comment, or congressional review of future decisions made by a nongovernment entity.

I want to be clear that I am not questioning the value of the DSM or the practice of medicine, or the process by which the manual is developed. But I believe giving the future decisions of a nongovernmental body the force of law raises serious constitutional questions. I would support a more balanced approach to mental health parity along the lines of the Senate bill.

I would ask my colleagues to vote ''no'' today so that we can take up the Senate bill and avoid a possible stalemate in a House-Senate conference on an issue that should be signed into law this Congress.

I would reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1½ minutes to the gentleman from Washington (Mr. BAIRD).

Mr. BAIRD. Mr. Speaker, this is indeed a landmark day in the United States of America in the history of health care because the Congress of the United States, the House of Representatives, is going to say that mental illness deserves treatment and people suffering from mental illness deserve to have that treatment covered under their insurance plans.

I want to commend JIM RAMSTAD and PATRICK KENNEDY for decades of work on this project. They are American heroes, in my judgment. They joined me for a field hearing in my congressional district where we heard from families, patients and providers about the toll mental illness takes on their lives.

As a clinical psychologist who spent 23 years providing mental health care, I want to share with my colleagues this simple fact. I have never met, and I am sure you have never met, anyone who has not been touched personally by a family member, a friend, or a coworker whose lives have been disrupted by mental illness. All of us in some way have been touched by mental illness, in our families, our friends, or our coworkers. What this bill does is say that people suffering from such illnesses will be covered under insurance plans.

I want to be clear about one thing. This is research-based, it is effective, it saves lives, and it saves dollars for our economy. Research-based, effective, it saves lives, and it saves dollars. This legislation supports it.

Congratulations, PATRICK KENNEDY and JIM RAMSTAD. I urge a ''yes'' vote on behalf of millions of Americans.

Mr. DEAL of Georgia. Mr. Speaker, I am pleased to yield 2 minutes to Mr. FERGUSON from New Jersey.

Mr. FERGUSON. I thank the gentleman from Georgia.

I rise in support of H.R. 1424, the Paul Wellstone Mental Health Addiction and Equity Act of 2007. This legislation brings treatment to individuals that desperately need the help. Addictions and mental illnesses are afflictions that have long been stigmatized and brushed aside by our society and institutions. Most of us have had a loved one or family member touched by mental illness or addictions. We know their painful stories all too well. Many individuals go years without treatment for serious illnesses due to society's stigma on mental illnesses. These individuals need and should receive the same care and treatment as if they had any other illness. However, I do have deep concerns about how this bill will be funded. Funding this legislation comes at the expense of United States medical researchers, which is ironic, since these are the folks who we look to to develop treatments for many of these very health conditions.

One of the offsets included in this legislation is a more than 30 percent increase in the Medicaid prescription drug rebate, which is a punitive and unwarranted move against the same medical researchers that we are relying on to find cures and treatments for illnesses and diseases. By increasing their cost and slapping a new tax on their work, we will be reducing their ability to invest in research and development of new products, new drugs. I believe that is profoundly shortsighted and misguided, and I believe it will set back the cause of research, which would ultimately lead to treatments for many of the diseases and afflictions that we are talking about here today.

Therefore, while I support and am a cosponsor of the underlying legislation, I urge that this particular misguided offset be struck from the bill as we negotiate with our colleagues in the Senate on a final version of this important legislation.

Mr. Speaker, I thank the gentleman, Mr. DEAL, for his leadership. I thank Mr. KENNEDY and Mr. RAMSTAD for their work.

Mr. PALLONE. Mr. Speaker, I would yield 4½ minutes to the gentleman from Rhode Island (Mr. KENNEDY), the sponsor of this legislation, who has been out on the road, and such a champion. I can't imagine what else to say about all his work on this.

Mr. KENNEDY. I thank the chairman for yielding me this time, and I want to thank him for all of his hard work and that of the other chairmen, Chairman DINGELL, Chairman RANGEL, Chairman MILLER, Chairman STARK, and obviously you, Chairman Pallone, for hosting that committee hearing in your district, as well as Chairman ANDREWS for all the work he did on this issue to bring H.R. 1424 to the floor today.

Without all of your markups, this bill would not have made it as far as it did today to come to this floor as one of the most important public health bills that we have seen on this floor in decades. Of course, that would not have happened had it not been for the great support of our Speaker, NANCY PELOSI, and Leader HOYER who without their support this would not have happened as well. I am indebted to them for their support.

Today, this House of Representatives takes up a truly landmark piece of civil rights legislation. Why civil rights? Because just as it would account for the color of your skin, or any other immutable fact about you, you don't choose if you're born with a congenital defect or if you're born with

one characteristic or another, just as you don't choose to have a predisposition to cancer, a predisposition to having asthma, a predisposition to dying early of one disease or another. And that applies true with those with mental illness. Yet when you have health insurance in this country, you expect to buy health insurance and it should cover your whole body.

□ 1645

But unfortunately, unbelievably, the brain is still relegated to that part of the world where people think of it as something that should be in your control, something that you should take charge of and so forth; that even though you might have a biochemical imbalance in your brain, that it is your fault if you have that biochemical imbalance in your brain.

So if you had diabetes and you don't produce enough insulin and you eat the wrong food and have sugar imbalances, no one holds it against you if you have complications to diabetes. But God forbid you have a dopamine imbalance in your brain that causes you to use alcohol or drugs, or you have a dopamine imbalance that has you in a depression or an imbalance in your brain that has you have a mental illness like schizophrenia. Then you are held to account because someone says that is your fault. And if you wander around the streets or if you are homeless, that must be your fault.

Those are the physical symptoms of a mental illness. Yet an insurance company will hospitalize you for the symptoms of a chemical imbalance called diabetes, but they won't hospitalize you for the physical and chemical imbalances of a brain illness as a result of dopamine imbalances or glutamate imbalances. What sense does that make? It doesn't make any sense. But it is stereotyped in an old dark ages mindset that has people hanging in the shadows because they are afraid someone is going to point someone out and say you should be ashamed of yourself because you have a mental illness.

My friends, I have a mental illness. I am fortunately getting the best care this country has to offer because I am a Member of Congress. If it is good enough for Members of Congress to have full parity, then it ought to be good enough for every American in this country who buys health insurance not to be discriminated against.

If we care about health care in this country, why are we not taking care of health care, rather than sick care? We ought to be taking care of people before they end up sick. We are spending in our emergency rooms too much money taking care of all of the acute cases as a result of mental illnesses, the car accidents, stabbings and intubations. Why not take care of people before they end up ending up in the emergency rooms? Why not take care of the people before they end up in our jails?

Let's pass mental parity, make this country stronger, make our people stronger, and let's make this day a great day for civil rights for all Americans.

I want to say this couldn't have been done without my good friend and colleague JIM RAMSTAD. Let's put this bill on the floor and do it this year and make it a tribute to Congressman JIM RAMSTAD, who has fought for this bill so long and hard.

Mr. DEAL of Georgia. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. TIM MURPHY), a member of the committee.

Mr. TIM MURPHY of Pennsylvania. Mr. Speaker, I thank the ranking member.

The CBO doesn't score savings. If it did, it would note that drug and alcohol addictions cost $400 billion each year, that depression costs employers $51 billion each year, that depression increases the risk for chronic illness, and that chronic illness and untreated depression doubles the cost of health care. It would also note that caffeine withdrawal and jet lag are not something that insurance companies pay for. In fact, they are not medically necessary. It is not occurring here.

But let's see what really happens with a person with mental illness, and I am saying this as a psychologist, as someone who has seen this time and time again, how the symptom really works. A person with a deadly disease such as anorexia or bulimia withers away until malnutrition and dehydration puts them in the hospital. Once the hospital stabilizes them, they come out. Maybe they will have a visit or two with a counselor or psychiatrist or psychologist. Maybe their primary care physician will put that person on some medication. And 75 percent of psychotropic drugs are prescribed by non-psychiatrists, by people not trained in the field, because they don't have treatment possibilities under their health care plan.

I oftentimes have a somewhat tongue-in-cheek agreement with obstetricians: I don't deliver babies, and they don't treat mental illness. Unfortunately, that may be all the plan allows for.

But let's look at us as Members of Congress. Out of 435 Members of Congress, out of the 10,000 employees on our side of the Hill, we know that there are hundreds, thousands of people, quite frankly, who at some point in their working career will have some mental illness. What do we do with a well-trained employee? Do we say, you're fired? Do we say, go out and suck it up? Do we send them out into the unemployment system? Do we send them out into the welfare system? Do we take our children and send them out to the educational system and say, let the school take care of it? If it is a family member, do we say, well, be part of the criminal justice system, perhaps go into the emergency room system? No. We have the situation as Members of Congress where we can say, no, you can get help and you can get treatment.

Why not for the rest of the country? Why not look at this as a cost-saving measure? This is more than just a compassionate measure. I speak as someone who has treated the mentally ill all my professional life, for 25 years. I know time and time again, when the people who are trained in this field to do something are told, no, you can't see this patient anymore, what do you say to the autistic child's parents? What do you say to somebody suffering from depression? What do you say to that person with anorexia or bulimia or any host of other problems when you have to say you are not covered, and so they are treated by someone with nothing in terms of experience in that field?

If we really want to save money, if we really are looking at things to help business, let's look at and see what AT&T and Pepsi and PPG and other corporations have said, that it saves them millions of dollars in indirect costs, billions of dollars.

Let's be honest about this. If we leave the system the way it is, we will see more wasted money. We will see more deaths. We will see more people mistreated or lacking treatment. Let's do the right thing.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to our distinguished majority leader, the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Speaker, I thank the gentleman for yielding, and I am pleased to follow my friend Mr. MURPHY who just spoke, with whom I agree entirely. This will be a cost savings. I want to congratulate as well PATRICK KENNEDY and JIM RAMSTAD, one a Democrat and one a Republican.

But this is not a partisan issue. This is not a Republican or Democratic issue. It is an issue of human beings. It is an issue of people that need help and have been denied it, people who are one of us, as Mr. MURPHY so eloquently and correctly pointed out.

I rise in strong support of this legislation. I strongly support this long overdue bipartisan legislation to end discrimination against patients seeking treatment for mental illness. Mr. KENNEDY spoke of that discrimination.

I want to commend Congressman KENNEDY and my friend Congressman RAMSTAD. Congressman RAMSTAD is going to be leaving us, but he has been one of the best Members that has served in this body, who looks at issues on their merits, not on partisanship. We all ought to do that.

This legislation, the Paul Wellstone Mental Health and Addiction Equity Act, now has 274 cosponsors on both sides of the aisle. Under this bill, an insurer or group health plan must ensure that any financial requirements such as deductibles, copayments, coinsurance and out-of-pocket expenses which apply to mental health and addiction treatments are no more restrictive or costly than the financial requirements applied to comparable medical and surgical benefits that the plan confers.

Why does it do that? It does it because in America we want healthy people; not physically healthy people or mentally healthy people, but people who are physically and mentally healthy, because obviously there is an extraordinary relationship between the two. Under this bill, we will accomplish that end.

It also requires equity in treatment limits. This means that the treatment limits, such as the frequency of treatment, number of visits and days of coverage applied to mental health and addiction benefits, are no more restrictive than the treatment limits applied to comparable medical and surgical benefits. Why? Again, because we want to effect the health of the individuals we are serving.

It is important to note that this bill only applies to insurers and group health plans that provide mental health benefits. That is, it does not require plans that do not currently offer mental health benefits to do so. It simply says, if you provide mental health benefits, do so equitably and fairly and equally. That is why PATRICK KENNEDY referred to this as a civil rights bill. It is a civil rights bill.

It also exempts businesses with 50 or fewer employees and businesses that experience an overall premium increase of 2 percent or more in the first year and 1 percent in subsequent years. We believe that perhaps will not happen, but it provides for it.

Research has shown that there has been no significant cost increase attributable to the parity requirement in the Federal Employees Health Benefits Program, which has made parity coverage for mental health care available to more than 8½ million Federal employees for 8 years. So we have had experience at this. This is not a radical departure. This is, however, the provision of equal treatment.

Furthermore, this bill's enforcement mechanisms are real, permitting the IRS to enforce and levy fines and penalties on plans for disallowing employers from deducting health care costs as an expense.

The two offsets in this bill were included in the Children's Health and Medical Protection Act, or the CHAMP Act, which passed the House last August. The first increases the rebate or discount that drug companies are required to provide State Medicaid programs for drugs provided for Medicaid beneficiaries. The second prohibits physicians from referring patients to hospitals in which they have an ownership interest, with the ability to grandfather existing physician-owned hospitals.

It is telling, Mr. Speaker, that this bill is supported by, among others, the American Medical Association, the American Hospital Association, the American Nurses Association, the American Psychiatric Association, and the American Psychological Association.

On the steps of the Capitol in a press conference with the Speaker, with Mrs. Rosalynn Carter, Mr. KENNEDY and Mr. RAMSTAD, as well as David Wellstone, I said that the United Negro College Fund has a wonderful phrase that it uses, and that phrase is that ''a mind is a terrible thing to waste.'' That is so very accurate. And if a mind is a terrible thing to waste, it is a terrible thing not to treat, as we would treat the broken arm or the diabetes or any other physical ailment.

This bill makes America healthier. This bill will save money. This bill makes good sense, morally and economically. Support this vital piece of legislation.

Mr. DEAL of Georgia. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Oklahoma (Mr. SULLIVAN), another member of the committee.

Mr. SULLIVAN. Mr. Speaker, I rise today in support of H.R. 1424, the Mental Health and Addiction Equity Act of 2007. I would like to commend Congressman KENNEDY and Congressman RAMSTAD for the work they have done on this bill.

There is a problem I have with it, though. I am disappointed with the offsets that are in there. I think these offsets do punish the pharmaceutical industry for participating in the Medicaid program, and it places financial limitations on physician-owned hospitals. Unfortunately, these offsets are essentially just a political game, and I hope at the end of the day they are not in this bill.

Mental health illness, if someone has a biologically based mental disorder, it is no fault of their own. They either have it or they don't. It is a chemical imbalance of the brain, and I think it should be treated like any other illness, and it is high time in this country that we do that.

This bill, people are going to say, we are going to score it, it is going to cost all this money. It is not. Some research says we spent $100 billion last year on untreated mental illness in lost productivity in the workforce in this country, and last year we lost $400 billion in lost productivity in the workforce due to substance abuse problems in this country. It is high time that we do not brush this issue aside anymore. We can't do it. It is costing us way too much.

My State of Oklahoma has the highest rate of mental illness in the United States of America. I don't know why, but we do, and we need to address it. That is why I was so glad that Congressman KENNEDY did come to my district to hold a field hearing there.

We heard from businesses. We asked them point-blank, one of the biggest employers in my district, we said, is this going to cost you money? He said, no, it will help us. It will save money. We talked to other people in the district about that as well.

People need this desperately. It is high time that we do treat people that have a mental disorder just like anyone else that has diabetes, a heart illness, or any other illness. I urge my colleagues to support this measure.

□ 1700

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the gentleman, who is our wonderful chairman of the Health Subcommittee in the House, for yielding. I want to begin by paying tribute to our colleagues, JIM RAMSTAD and PATRICK KENNEDY. They came to my congressional district for a hearing, and there was an outpouring. But, in addition, there was an outpouring across the country and I believe that they carried a candle across the country and that candle has lit the way. They lit the way with their integrity, with their courage, with their patience to listen, and their legislative craft of the bill that is brought before the House today. So to both of you, I salute you and the country thanks you.

America is best when we see where we have not done right, where there is a wrong, and we correct it. Congressman KENNEDY said today that this is civil rights legislation, and it is. Every Member of the House should recognize that, today, we have the opportunity to break down a barrier, one of the last barriers in our country where those that have mental illness are indeed discriminated against in the insurance system of our country.

Now there are some in my congressional district that have led the way. Tony and Fran Hoffman helped to found the National Association of Mental Health. Eve Oliphant has worked for that. And I am really proud that David Wellstone, the late Senator Wellstone's son, is a constituent as well.

There are some very important points that have been made about the bill. There are also many things that have been thrown at it. For those that say that jet lag is going to be paid for by insurance companies, don't insult people that have mental health illnesses in our country. That will not happen. So, my colleagues, let's pass the civil rights legislation today. We will do the country good by doing so.

Mr. DEAL of Georgia. Mr. Speaker, I am pleased to yield 4 minutes to the ranking member of the Energy and Commerce Committee, the gentleman from Texas (Mr. BARTON).

Mr. BARTON of Texas. I want to thank Congressman DEAL for his excellent leadership of this issue and floor time and his demeanor and ability to coordinate the effort. I really appreciate that.

Mr. Speaker, I, along with every Member of this body, am very concerned about the almost invisible illness which we call mental illness. There is absolutely no question that it is real. There is no question that we need to do more to alleviate it and treat it and, if possible, make it possible for those that have it to be cured of it. Unfortunately, the bill before us today doesn't do that.

We are in the process of putting together a bill that, if it passes in its current form, does nothing more than bureaucratize, in my opinion, the treatment of mental illness. It goes so far as to put the entire catalog of various diagnoses into Federal statute. I don't think that makes a lot of sense. This Diagnostic and Statistical Manual has numerous categories that are very real abuses, very real problems, but I think it is a debatable proposition whether they constitute mental illness.

For example, code V71.01 of the Diagnostic and Statistical Manual covers professional thieves, racketeers, and dealers in illegal substances. Now in my book, those are thugs and criminals; they are not people suffering from a mental illness. And I don't want, if this bill were to become law and the Diagnostic and Statistical Manual be put into Federal statute, for a criminal defense attorney to stand up in court and cite this law as a reason that their client should be treated for mental illness and not be subject to criminal penalties and hopefully, if proven guilty, put behind bars.

There is a better bill. It is a bill that has come out of the other body. It is a bill that was put together in the other body with bipartisan support. In my opinion, it is a better bill than the bill before us. I would hope that at the appropriate time we might work with the other body and adopt more of that language than the language before us.

Finally, Mr. Speaker, I am concerned that this bill came before us under a closed rule. We did have an open debate in the committee and I want to commend Chairman DINGELL for that. But coming to the floor, we were offered no substitute. We were offered no amendments.

I am also concerned about the offset. The offset is an attack on physician-owned hospitals. And it is kind of odd that the same provision that the CBO now scores as saving hundreds of millions of dollars over 5 years and billions over 10 years, 3 years ago had no savings at all when we looked at a similar provision in the Budget Reconciliation Act.

So I would oppose this on procedural reasons and also policy reasons and hope we would defeat it and then work with the other body on some version of the bill that has already come out of the other body.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, this bill has been a long time coming, and I am sure Senator Wellstone would both be pleased to see us addressing this issue, finally, and also so, so proud of our colleagues, Mr. KENNEDY and Mr. RAMSTAD. The bill will provide countless protections to patients by preventing discrimination and treatment limitations by insurance companies.

All too often I hear stories about children with eating disorders, parents who are substance abusers, individuals with bipolar disorder, or any other number of mental health disorders who have been unable to access coverage for mental health services. These disorders are just as great as any physical malady and, frankly, oftentimes they have a greater impact on an individual's ability to live a healthy, happy life as a productive member of society.

Last year, during our hearing on this bill, for example, we heard from a woman named Marley Prunty-Lara, who was diagnosed with bipolar disease at the age of 15. Her family had to take out a second mortgage on their home and move to another State just to afford care. However, with proper treatment, she is now a fully productive member of society and in fact credits her treatment for saving her life.

What I remember most vividly from her testimony is how lucky she felt that her family was able to afford coverage although they had to make sacrifices to do so. And then I thought, what about all of the other individuals in this country whose insurance companies do not provide them with mental health benefits and cannot afford treatment? What about the individuals whose benefits run out before they have fully recovered? And what about people with chronic conditions? Just like my little 14-year-old daughter has type I diabetes, she will get the treatment she needs for the rest of her life. But what about people with mental health conditions who do not? We know that mental health is fundamental to good health. That is why we need to support this legislation.

I find it interesting that we are addressing the question of how we as a society want to pay for mental health at the same time as we are addressing the same question in the context of the President's budget and health care for children. I honestly hope that we can pass this legislation today and finally put the days of discrimination toward individuals with mental health or substance abuse disorders behind us. It is time to finally pass the Paul Wellstone Mental Health and Addiction Equity Act.

Mr. DEAL of Georgia. I am pleased to yield 2 minutes to another member of the committee, the gentleman from Indiana (Mr. BUYER).

(Mr. BUYER asked and was given permission to revise and extend his remarks.)

Mr. BUYER. I support the Senate-passed version of the mental health parity legislation. It was carefully crafted between mental health groups and business groups. And everyone should note that not all of the mental advocacy groups support this House language. They see some dangers in it.

In particular, in the bill that we are discussing, employers are allowed to drop their mental health benefits, and there is great concern that employers in fact will do that because of the overly broad coverage mandates as specified in the Diagnostics and Statistical Manual which is included in this bill.

The American people must know that the bill before the House today, again, is not supported universally by mental health advocacy groups as the Senate bill is. HEATHER WILSON offered an amendment in the committee; it was defeated. I am very disappointed that no amendments were offered in the Rules Committee. This is, once again, shutting down the democratic process of this House.

I don't know what you have to fear. I am really concerned about that. I am also concerned about the pay-fors for this. To substantially increase the Medicaid prescription drug rebate as one of the offsets, this significant increase could have a detrimental impact, because when you increase these rebates, there is going to be a cost shift, and that cost shift is going to have a depreciative effect. The effect will be you will increase the price on premiums, you will have an increased price of drugs on someone else.

Also, I am very bothered that the second pay-for of the bill would limit Americans' access to the specialty hospitals. These are benefits that so many people are enjoying, these specialized hospitals. They have higher patient satisfaction, lower mortality rates, and lower overall costs for health care. So at a time when our Nation's health care costs are rising and the quality of our care is a top concern, I am very bothered that this provision would cut out that important market innovation.

Mr. PALLONE. Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. I first want to congratulate the sponsors and thank them, Congressman KENNEDY and Congressman RAMSTAD, for their tireless effort on behalf of this bipartisan bill. I also want to pay tribute to Paul Wellstone. He and his wife Sheila were very good friends of me and my family. They were both leaders in ending discrimination and making sure that every person in this country has access to affordable comprehensive care, including comprehensive mental health and substance abuse treatment.

And, if Paul were here today, he would no doubt tell some stories about those he had met throughout the years who would benefit from passing H.R. 1424. And in his absence today, I remember the many, many constituents who I have heard from since first being elected to the Illinois State legislature many years ago who shared with me the need, their desperate need to pass mental health parity legislation.

Every year, about 40 million of us will experience some type of mental disorder; yet one out of every two children and two out of every three adults with diagnosable mental disorders go without treatment.

The good news is that so many mental illnesses are manageable and treatable and curable. The bad news is that, for so many, treatment for mental illness lies far beyond their reach due to high cost sharing and lower caps on services.

Some have said that using the handbook that defines mental health illnesses and is used by the mental health professionals somehow will add to the costs and jeopardize access altogether. But when implemented in the Federal Employee Health Benefit Program, our own program, in 2001, costs did not increase and not one single insurer dropped out. If we are able to benefit from this level of coverage, shouldn't our constituents get at least that much?

Maintaining strong mental health is just as important as maintaining strong physical health, and it is critical that we pass the strongest parity bill we can today.

Mr. DEAL of Georgia. Mr. Speaker, I am pleased to yield 1 minute to my colleague from Georgia (Mr. BROUN).

Mr. BROUN of Georgia. I thank the gentleman for yielding.

As a physician, I have been involved in treating mental illnesses and my family has suffered from mental illnesses, and I have a tremendous interest in this area. But this bill is going to actually drive people away from being able to have health insurance coverage.

There are many things about this bill that are wrong and bad. I know it is well-intended, but I highly encourage people to vote against this bill because, though the bill is well-intended, I think it is going to cause disastrous effects and I think employers are going to opt out from giving their employees mental health coverage on their insurance. So I highly encourage my colleagues to vote against this bill.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Connecticut (Mr. MURPHY).

Mr. MURPHY of Connecticut. Mr. Speaker, right now there are millions of patients and families around this country who are too scared to talk about the mental illness they are dealing with. They are too scared to go and seek treatment for that mental illness.

□ 1715

And there are millions more in this country who are living in denial, thinking they can just wish away their debilitating illness.

The legislation that we are passing today, that States like Connecticut and others around the country have been passing for the past 10 years, it is going to do a lot to get treatment to those who have insurance.

But I think just as importantly, it says this, it puts the full power of the United States Congress behind the effort to lift that veil of shame and secrecy that too often visits families and patients who are living with mental illness. Mr. KENNEDY and Mr. RAMSTAD are true heroes to those families dealing with mental illness today, and on their behalf, I thank them.

Mr. DEAL of Georgia. Mr. Speaker, I yield the balance of our time, 2 minutes, to a member of the committee, the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, as a physician, I understand the high cost of treating mental illness and substance abuse. I am also personally familiar with how the cost of this care can keep people from receiving the help that they need. But the bill before us does not solve the problem. In fact, it creates some new ones.

The bill is problematic for a multitude of reasons, and we can visit but a few of them. No insurance plan covers every possible physical diagnosis. Then why are we insisting that insurance plans cover every possible mental health or addiction diagnosis no matter the medical significance?

This bill will cost Americans more money and could cost Americans health benefits. According to the CBO, H.R. 1424 will drive up the cost of health insurance for everyone and lead some employers to drop mental health insurance benefits completely.

Another problem is the codification of the Diagnostic and Statistical Manual of Mental Disorders. The DSM-IV is not designed for legal use. It was designed for clinicians so we can adequately diagnose and adequately measure the response to therapy.

The Senate bill, on the other hand, is reasonable. It has been developed with input from patient advocates, mental health providers, and employers. This bill has offsets, and the offsets are counterproductive, such as limiting physician ownership in specialty hospitals. They are very few in number, but specialty hospitals are strong in quality and performance. Maybe that is why the Democrats feared them: They represent high-quality performance that results from competition.

For example, in my area in Texas, Baylor Health in Dallas was named the recipient of the National Quality Forum's 2008 National Quality Healthcare Award. Baylor has a joint venture, a partnership, with physicians sharing ownership of its facility. The bill before us today jeopardizes the high level of care and patient access to care provided by facilities such as Baylor.

The basis for savings calculated by the Congressional Budget Office is flawed data; and quite frankly, it is not relevant to the delivery of health care in the 21st century. And once again, we have another example of how this House leadership will choose politics over policy to the detriment of the American people.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. ALTMIRE).

Mr. ALTMIRE. Mr. Speaker, last March Congressman KENNEDY came to western Pennsylvania to hold a hearing with me and Congressman TIM MURPHY about the critical need for mental health parity legislation. Now, almost exactly 1 year later, I am proud to rise in support of the Paul Wellstone Mental Health and Addiction Equity Act. This much-needed legislation will eliminate the discrepancies between health insurance coverage for mental and physical illnesses by ensuring that patients seeking mental health services are no longer penalized with higher copayments and coverage restrictions.

Passage of this bill is a key step towards ending the stigma surrounding mental illness. Of the 44 million Americans living with mental illness, two-thirds did not receive the treatment they need. Treating mental illness is not only critical to mental health, but also prevents physical ailments that arise when mental health conditions go untreated.

So, Mr. Speaker, this bill will help improve the mental and physical well-being of millions of Americans, and I ask my colleagues to support this bill.

Mr. PALLONE. Mr. Speaker, I reserve the balance of my time until the end of the debate.

The SPEAKER pro tempore. The gentleman from California (Mr. GEORGE MILLER) is recognized for 20 minutes.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I rise in very strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act, named in honor of the late Paul Wellstone, who fought vigorously for better treatment for mental illness.

We in the Congress have known for many, many years, and so many of our constituents in our communities that we represent have known for so many years, the need for coverage for those individuals who need mental health treatment, whether it is for themselves or members of their family, and the difficulty in not only having coverage, but providing that care and to make sure that some form of that care is reimbursed. This has been a struggle for many years.

Today we address that struggle head-on with the consideration of this legislation, but we would not be standing here today without the efforts of Paul Wellstone and all of his efforts to rule out the discrimination against individuals in need of mental health services. He is joined in that fight, and they have led that fight, by Congressman PATRICK KENNEDY and Congressman JIM RAMSTAD. Again, we would not be here today debating this legislation and hopefully later this evening passing this legislation so that we can, for the first time, offer as a matter of national policy the idea that there would be parity in the coverage between physical illnesses and mental illnesses, to make sure that those people can get that coverage, can get the treatment that is necessary, can get the care that is necessary for them and for their families.

Yes, the fact is that a number of States have laws governing this treatment for mental illness and the reimbursement for those services, but Federal law still hampers the reach of many of those laws. And as a result, many of the people who would be otherwise covered are not covered, and they continue to suffer under those discriminatory practices, and they fail to

get the services that they need so they can live a better life and so their families can live a better life.

Today we get an opportunity because of the hard work, the efforts that Congressman RAMSTAD and Congressman KENNEDY have made to travel this country, to talk in communities all across the country, to inform them and to discuss with them the possibilities of this legislation, what it would mean to individuals, what it would mean to families, what it would mean to the general health care in this country. They have taken on that mission, and they have convinced, I think, the vast majority of the country, and they have certainly enlisted those who understood the problem before their appearances that this is a problem that we need to address and we need to address now and we need to address in the most comprehensive fashion that we can.

This legislation doesn't do all that I would like to see it do. It doesn't do all that Congressman KENNEDY or Congressman RAMSTAD would hope that it would do. And it doesn't do all that Paul Wellstone wanted us to do in terms of eliminating all of those discriminatory provisions. But it is a magnificent start, and we should begin by passing this legislation today.

Mr. Speaker, at this time I yield to the gentlewoman from New York (Mrs. MALONEY) for a unanimous consent request.

(Mrs. MALONEY of New York asked and was given permission to revise and extend her remarks.)

Mrs. MALONEY of New York. Mr. Speaker, I rise in strong support of this bill. It is long overdue.

Mr. Speaker, I rise in strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act.

This bill requires group health plans to cover mental health and substance-related disorders the same way they cover medical and surgical disorders.

It's time we permanently end discrimination on the basis of illness.

We all know that mental illness is just like any physical illness. But we would never think of limiting treatment for cancer, heart disease, or diabetes.

People would be outraged.

So, it's amazing to me that some people still see mental illness as different and separate from physical illness.

In New York City, since 9/11, we have all seen an increase in the number of people seeking mental health services.

No one should feel ashamed for seeking needed healthcare and no one should be denied care simply because they cannot afford it.

More than ever, our returning soldiers, our firefighters, and our police officers, are suffering from traumatic events and need the proper care.

Our soldiers are coming home from Iraq and Afghanistan suffering from Post Traumatic Stress Disorder and other mental health problems.

Too often, the stigma associated with mental health prevents them from seeking the care they so desperately need.

In my own district, our police officers and others are still coping with the horrors they witnessed after the tragedy of 9/11.

Thanks to the New York City Police Foundation's program, Project COPE, civilian and uniform members of the New York City Police Department (NYPD) are able to access mental health services.

Project COPE is an example of an outside group providing mental health services because too many people are going without proper treatment.

I am proud that today, as a bipartisan body, we will pass legislation that will help ease access to treatment and will help millions of people and their families battling mental illness.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 3 minutes to Mr. ANDREWS of New Jersey.

Mr. ANDREWS. Mr. Speaker, I thank my chairman for yielding and commend Congressman KENNEDY and Congressman RAMSTAD for bringing this bill to our attention.

Someone who is struggling with substance abuse addiction or bipolar disorder, they shouldn't be under a different set of rules for getting their bills paid by their insurance company than if they had a knee injury. That is what this is about. If you have a $500 deductible for knee surgery, you ought to have a $500 deductible for your care for alcoholism or drug treatment or bipolar disorder. The insurance industry would be required to do that under this provision.

What would be wrong with that? Why would people be concerned about this? The first argument that we have heard is that there is a defined set of benefits that would have to be offered here to protect people with mental health and substance abuse issues. Well, there is a reason for that, because the insurance industry in this country has made it a practice of telling us what they don't cover. It is a cottage industry for people to find out that procedures are experimental or there is not enough justification. People find out every day that coverage they thought they had is no longer covered.

The second objection we hear from people is that this costs too much. That directly contravenes the evidence. As a matter of fact, the evidence shows over the long haul this saves money. And in the worst case scenario, the premium increase because of mental health parity laws is 0.6 percent per year, a minimal cost that is far outweighed by the benefit.

Finally, we hear concerns about small businesses. This provision exempts small businesses of 50 and fewer employees.

This is simple good sense. It says that a substance abuse problem or mental health issue should be treated under the same rules for getting your bill paid by your insurance company as a knee operation would be. Mental illness and substance abuse reaches across racial lines, class lines, religious lines, and geographic lines. It reaches into many, many families, including families represented in this institution.

This is a reform that is long overdue. It is why it is a reform that has support from both Republicans and Democrats. I would urge my colleagues on both sides of the aisle to take a commonsense step towards helping families across this country and vote ''yes'' on this much-needed piece of legislation.

The SPEAKER pro tempore. The gentleman from California (Mr. MCKEON) is recognized for 20 minutes.

Mr. MCKEON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in opposition to H.R. 1424. Today we are attempting to enact legislation that achieves ''parity'' in the treatment of employer-sponsored coverage for mental and behavioral illnesses. However, although the House bill is well-intentioned, it does not accomplish the goal of providing parity. Instead, it creates new mandates so onerous that they could do far more harm than good, potentially squeezing employers out of the voluntary health care system altogether or eliminating the very mental health benefits we are trying to provide.

First, this bill would give preferential treatment in our health care system to mental health benefits, affording mental illness a special status that is not given to other similarly severe medical illnesses.

For example, under the House bill we are considering today, virtually every mental illness defined by the mental health profession would be required to be covered by private plans. This, despite the fact that most States currently do not mandate this type of coverage. Also, H.R. 1424 does not place a similar requirement on private health plans to cover other types of medical benefits, including hospital services, physician services, drug benefits, or any other category of benefits. What this bill really accomplishes is not ''parity'' between mental health coverage and the medical and surgical benefits that are offered by plans; it is quite simply preferential treatment for mental health benefits over and above all other categories of medical benefits. The changes that have been made to the floor version of H.R. 1424 fail to address these serious concerns.

Second, we have heard the bill's supporters say that this is a balanced bill. Respectfully, it is not. The bill fails to adequately and explicitly protect the ability of private plans to apply commonsense medical management practices currently being used to help ensure the delivery of high-quality medical care and ensure that coverage for working men and women remains affordable.

□ 1730

Under this bill, plans would likely have to pay a mental health provider's bill without question, which would make it very difficult to control costs.

Third, this bill unnecessarily weakens the preemption requirements in the ERISA law. As a result, States would be free to enact standards greater than the Federal standard. Although the majority may argue that ERISA preemption is maintained, their language,

at a minimum, raises serious questions about the ability of States to enact laws and remedies that preempt ERISA and impact group health plans that currently operate under Federal law.

Litigation to determine the meaning of this provision will result and group health plans could be subjected to possibly 50 different State laws on mental health benefits, making it harder to provide one set of rules that apply to all plans. This violates a fundamental rule of ERISA, which creates efficiencies by preventing plans from having to comply with 50 or more different sets of laws. One set of rules, applied equally to all ERISA plans, makes high-quality coverage affordable and available to millions of Americans. If the majority were truly interested in preserving ERISA, they would have adopted the noncontroversial language contained in the competing Senate mental health parity bill.

Fourth, the bill mandates out-of-network coverage if any other benefit is operated on an out-of-network basis. This mandate will prevent plans from coordinating medical care, which will reduce quality and increase the cost of coverage.

Lastly, this bill will increase litigation against ERISA plans by permitting application of State remedies to federally mandated benefits. There will be absolutely no consistency in State court rulings, and litigation costs could skyrocket.

Mr. Speaker, while the broad issue of mental health parity enjoys widespread support, this bill does not. It is not a negotiated compromise between all parties that have a stake in this debate and, therefore, it is not in the best interest of the country as a whole.

However, a viable alternative to the House bill with broad mainstream support already exists and has passed the Senate. The Senate's bipartisan bill has extensive support from mental health advocates, health care providers and business groups representing virtually all sides of this debate. The Senate bill is the product of years of bipartisan negotiations which accomplishes exactly what it sets out to do, provide parity for mental health benefits. It clearly reflects a more balanced and viable solution, and has a much better chance of becoming law if it were considered and passed by the House. Sadly, the majority has refused to consider that legislation, and instead offers the bill we are debating today, which gives preferential treatment to one particular class of medical benefits and has little or no chance of becoming law. Unfortunately, passage of the House bill will likely make it much more difficult to pass meaningful parity legislation this year.

For the reasons stated, I must oppose this bill and encourage my colleagues to do the same.

Mr. Speaker, I reserve the balance of my time.

The SPEAKER pro tempore. Without objection, the gentleman from New Jersey will control the time of the gentleman from California.

There was no objection.

Mr. ANDREWS. Mr. Speaker, at this time I would like to yield 30 seconds to the author of the bill, the gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY. I just want to take issue with the point that this is giving some kind of preferential treatment to mental health benefits. If the gentleman would yield for a second on the point, we're having to state that mental health benefits need to be in the bill because no one questions when you get a broken arm, that it's automatically covered. But if it's a mental illness, it's discriminated against. Why we have to put this in the bill is because if we don't, it gets discriminated against. It's as simple as that. That's why we're on the floor today because we have to put it into civil rights law so it's not discriminated against. That's why we're on the floor today. That's not preferential treatment.

Mr. ANDREWS. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from Iowa (Mr. LOEBSACK) who has been a vigorous advocate for mental health issues since his arrival here.

Mr. LOEBSACK. Mr. Speaker, I rise today in strong support of the Paul Wellstone Mental Health and Addiction Equity Act. This bipartisan bill is the product of many months and even years of thoughtful negotiation, and I congratulate the authors of this legislation, Congressman KENNEDY and Congressman RAMSTAD, on their work to move this bill forward. And I might add that I did know Paul Wellstone, and I knew Sheila very well, too, and I know the both of them were strong advocates on this issue.

I, like many others, have personally felt the effects of mental illness in my family. My mother struggled with mental health issues for as long as I can remember, and I know firsthand how difficult and draining her struggle was.

We have all heard the statistics. One in every five people in our country will experience a mental illness this year. Many of these individuals will seek treatment, and without this legislation many would be denied. This is unacceptable.

I hope today this House will understand the importance of equal access to treatment for those suffering from mental illness. I was elected to this House to do the right thing for the people of the Second District of Iowa and the right thing for the people of America. This is the right thing to do, and I urge my colleagues to support this bill.

Mr. MCKEON. Mr. Speaker, I yield 5 minutes to the gentlelady from Oklahoma (Ms. FALLIN).

Ms. FALLIN. Mr. Speaker, I'm here today to speak in opposition of H.R. 1424. This bill, although well intended, comes with a long series of unintended consequences. And while I fully support the bipartisan efforts to bring parity between mental health and medical benefits and employer-sponsored health care plans, I cannot support this bill as it is currently written. In fact, in my mind, this legislation will diminish care for patients, will increase costs, will restrict access to care, will restrict access to specific hospitals and doctors, along with hurting the financial investments made personally by doctors and specialty hospitals.

Oklahoma has one of the highest concentrations of specialty hospitals in the Nation, and I've had the opportunity to visit a large percentage of them. These specialty hospitals offer very good quality care with physicians who are trained specifically in areas of expertise to deliver to their patients.

These facilities offer specialties anywhere from hip and bone replacement to gynecology, to cardiology, to heart hospitals, spine hospitals, and they do provide some of the best medical care possible in the whole Nation. In fact, some of our hospitals have grown by leaps and bounds because they have people coming from all over the Nation, and they've even been rated as some of the top hospitals in the Nation.

By interfering with the ability of physicians to refer their patients to specialty hospitals, this bill will throw up a legal barrier to good medical treatment. I personally believe that competition is good in a marketplace. It improves the delivery of services. It improves the quality of services and delivery of care. It also offers greater transparency of pricing. We talk a lot in this Congress about patients knowing the price of medical care. It also offers greater transparency in the quality of care, the outcomes of the care so patients can make better choices about their treatment and become more informed about their treatment.

Specialty hospitals and medical specialties also allow doctors new ways for innovation and treatments, new techniques. They bring new techniques and innovations to the marketplace that might not always be there in our regular hospitals. And they've also shown in many cases to have better health outcomes because their doctors specialize in these particular medical practices.

This legislation would restrict patient choice to not be able to choose doctors who would specialize in a heart procedure and a hip replacement or maybe even delivery of babies.

Specialty-owned hospitals have also documented that they can have shorter stays, that they have lower infection rates, sometimes up to 50 percent lower infection rates, lower infection rates of staph infection and lower risk of illness. When you take a person who is going in for a hip replacement and you put them in a hospital with someone who has the flu, you put that person at risk of getting another illness. And when you have a specialty and they're going in for a hip replacement and that's their illness, there's less risk of another illness coming upon that patient.

We also find that a large portion of our medical specialty hospitals take big portions of Medicare patients. I know that that's been a big concern. They are Medicare certified. In fact, many of the hospitals take up to 65 to 70 percent Medicare patients in their facilities. And many of them are required to have the emergency rooms. McBride Hospital, for instance, in Oklahoma City is the third largest hospital in the whole Nation for hip and bone replacement, and people come, as I mentioned, from all over.

They're also required to meet all the procedure requirements of a full-blown hospital. We find that the other hospitals in our community often refer their patient to our specialty hospitals.

If you look at other systems that have rated specialty hospitals and these practices, HHS, MedPac, GAO have studied physician-owned hospitals, specialty hospitals, and found no negative impact on general hospitals. In fact, I heard one speaker say today that 3 percent of our Nation's hospitals are specialty hospitals.

It also has found that there's no evidence of increased utilization by physicians in facilities in which they own, which they have ownership.

And, of course, specialty hospitals have created jobs and investment in our community and have some of the best rated services in our whole Nation.

So today, Mr. Speaker, as we are considering this mental health parity bill, which is an important subject, I find language that I believe will be a disservice to patient choice, patient quality of care in our Nation.

Mr. ANDREWS. Mr. Speaker, may I inquire how much time is remaining on each side.

The SPEAKER pro tempore. The gentleman from New Jersey controls 12½ minutes. The gentleman from California has 9½ minutes remaining.

Mr. ANDREWS. Mr. Speaker, at this time I am pleased to yield 2 minutes to a gentleman who has become expert on both the military and civilian health care system, my friend and neighbor from Pennsylvania (Mr. SESTAK).

Mr. SESTAK. Mr. Speaker, I rise in support of H.R. 1424 for three simple reasons based upon my experience in the U.S. military:

First, today we're seeing 17 percent of those who wear the cloth of our Nation in Iraq and Afghanistan returning with post-traumatic stress disorder. And over one-third are returning with a mental disorder from anxiety to depression. They will feed into our society. How can we not give them the same parity as we do to those who are double amputees and we give prosthetics?

Second, again in the military we put money in in order to prevent a greater crisis. We were the insurance for this Nation. Presently, we spend up to three times the cost, indirect cost of mental illness as it would take for the treatment. How can we not pursue this, both for the good of the individual and the cost-benefit for our society?

And the third simple reason is, I honestly do believe in the ideals that Hubert Humphrey said. The moral test of our government is how well it takes care of those in the dawn of life, the children, those in the twilight of life, the elderly, and those in the shadows of life, the sick, the disabled, the handicapped. I'm sure he would have included in that the mentally disabled, the largest disability in America.

Mr. MCKEON. Mr. Speaker, I'm happy to yield now 4 minutes to the gentleman from Georgia (Mr. BROUN).

Mr. BROUN of Georgia. Mr. Speaker, I spoke earlier today about my grave concerns about this bill. I noted that I did my very best to offer amendments to this bill that would mitigate some of the damages that this bill will cause, which will include increased health care cost, and an actual decrease of mental health coverage for many Americans.

What my very sincere but misguided colleagues on the other side of the aisle repeatedly forget is that actions have consequences. When Congress chooses to impose billions of Federal Government mandates on the private sector, they somehow seem to believe that the money that it will take to pay for those mandates will just somehow drop out of the sky or grow on trees. I'm here to remind them that it doesn't. Someone must pay for it.

There's a great thing that we call the free market in America. I'm an ardent capitalist, and I believe that the marketplace, unencumbered by government regulation, is the best way to control quality, quantity and cost of all goods and services, including health care.

The reality is when government steps in and tries to improve the marketplace, they impede and harm the efficient delivery of goods and services, and this definitely includes mental health care.

□ 1745

Please understand me. I'm in complete agreement that mental health is an extremely important issue, but we have over 200 years of capitalistic experience in America that proves beyond a shadow of a doubt that heavy-handed government regulations just simply do not work, no matter how well-meaning they are.

We in Congress will harm Americans if this bill passes. We are trampling on the private sector, punishing employers that already offer a mental health coverage to their employees. We're harming Americans that desperately need mental health coverage, and we're trampling on the Constitution which does not give us the right to impose these restrictions and mandates on the American people and American businesses.

It is an undeniable fact that this bill includes private sector mandates in billions of dollars. It's also a fact that one thing this bill does not mandate is that employers provide mental health coverage, but for any employer that does provide that coverage, and many do and they're commended for doing so, Congress is now going to greatly increase their costs and put regulations on them in their doing so.

And in turn, what will they do? Just grin and bear it? Well, some likely will, possibly cutting costs in other areas, but there will be undoubtedly many businesses that cannot afford these burdens and will simply drop mental health coverage. That will be a shame, and it will be Congress' fault.

The real solution to health care costs, and that's all our health care costs, and the coverage is to stop these mandates and get the regulatory burden off of the health care system, including providing mental health care.

Mr. ANDREWS. Mr. Speaker, at this time I'm pleased to yield 1½ minutes to a very powerful voice for the voiceless, the gentlelady from New Hampshire (Ms. SHEA-PORTER).

Ms. SHEA-PORTER. Mr. Speaker, I rise this afternoon to voice my strong support of this bipartisan legislation. I became an original cosponsor of the Paul Wellstone Mental Health and Addiction Equity Act of 2007 because I recognize the inequities in our health insurance system.

As a social worker and administrator, I saw firsthand that insurance companies did not cover mental illnesses the same way they covered other illnesses. This created extra strain on patients, families, and health care providers in the communities they live in. Requiring higher deductibles and copayments also blocked access to health care for many.

H.R. 1424 remedies these problems by requiring mental health parity. There should be no difference between a pain in one's abdomen and mental pain or the pain of addiction, but these patients and their families do not receive the same support and help to stabilize their condition and walk the road to recovery. This is wrong and it's time to remedy this discrimination.

I urge my colleagues to vote ''yes.''

Mr. MCKEON. May I inquire as to the amount of time remaining.

The SPEAKER pro tempore. The gentleman from California (Mr. MCKEON) has 6 minutes remaining. The gentleman from New Jersey (Mr. ANDREWS) has 10 minutes remaining.

Mr. MCKEON. I'm going to be our last speaker.

Mr. ANDREWS. I have others I can yield to.

Mr. MCKEON. I'll reserve.

Mr. ANDREWS. Mr. Speaker, I'm pleased to yield 2 minutes at this time to a gentleman who really understands the interface of insurance and health care law, the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Mr. Speaker, I rise in strong support of the Wellstone Parity Act. This legislation will move our country forward to a more intelligent,

humane, and cost-effective health care system.

Intelligent because it recognizes a scientific fact, that mental illness and disease can be diagnosed and treated like any physical illness and disease.

Humane because it will provide relief and care for millions who suffer needlessly.

And cost-effective because providing access to primary mental health treatment saves much more expensive catastrophic health care costs and increases productivity of workers suffering from illnesses such as depression and alcoholism.

This is not just a theoretical claim, Mr. Speaker. States like the State of Connecticut, which I come from, have had an operational parity bill for a number of years. It is precisely because of that fact that the carefully crafted language surrounding ERISA by the Education and Labor Committee was designed to protect existing parity laws for State-regulated health care plans. We did not want to have a bill that resulted in States ending up going backwards rather than forwards, and commissioners from States like Wisconsin and Connecticut weighed in and advised our committee to, again, make sure that we design the ERISA language carefully to protect State-regulated plans.

Finally, this legislation adheres to fiscally sound PAYGO rules. And on that note, I would again salute the work that's been done and will work to make sure that these policies in the bill will not stifle research and development for new medical cures and treatments to help those suffering from mental health and addiction problems.

Again, I urge passage of this strong, bipartisan legislation. It is long overdue that our country move in this direction.

Mr. ANDREWS. Mr. Speaker, I'm pleased to yield 2 minutes to my friend and neighbor from the State of New Jersey, Mr. HOLT.

Mr. HOLT. Mr. Speaker, I thank my friend, Mr. ANDREWS.

Mr. Speaker, it will be a landmark day when we realize that health is not just about fixing broken bones. It's about having a healthy, complete individual from head to toe.

Today the House takes an important step to require mental health parity in insurance, and I particularly want to thank and recognize PATRICK KENNEDY and JIM RAMSTAD, and the late Paul and Sheila Wellstone.

Mr. Speaker, millions of Americans suffer from mental illness of some form. Few Americans are untouched and no one is immune.

Some of my colleagues have expressed their concern about the cost of providing mental health parity; yet an analysis of the bill indicates that it would result in an increase of less than 1 percent in premiums and would reduce out-of-pocket costs by about 18 percent. Further, according to a recent article in the Journal of the American Medical Association, employers who actively encourage their employees to use mental health services actually experience better health outcomes and, I want to emphasize this, increases in hours worked and productivity gained.

I include in the RECORD an editorial from the Journal of the American Medical Association from last September of 2007 dealing with the treatment of depression.

REDUCING THE BURDEN OF DEPRESSION—BUILDING VILLAGES FOR COORDINATED CARE

(Kenneth B. Wells and Jeanne Miranda)

In this issue of JAMA, Wang et al provide evidence that implementing depression care programs through employer-sponsored managed behavioral health can improve clinical outcomes, job retention, and effective hours worked compared with usual care. The programs encouraged depressed workers to learn about and use evidence-based depression treatments, supported clinicians in following practice guidelines, and offered telephone counseling and self-help workbooks. The monetary value of the increased work time under the program exceeded the direct intervention costs and likely exceeded or was within the range of cost increases due to greater mental health specialty use under the intervention. While formal estimates of cost-effectiveness and employer return on investment are pending, it appears to be in the business interests of many employers to implement such programs to protect their investments in the retention and productivity of workers they have hired and trained.

These findings should be evaluated within the context of the simple but startling facts about depression. Clinical depressive disorders are among the most prevalent of major medical conditions, affecting about 16% of adults in their lifetime. Owing to high prevalence, early age at onset (unlike other debilitating disorders that occur past the age of parenting and work responsibilities), and strong impact on functional status, depressive disorders are leading contributors to disability worldwide. Depressive disorders are highly treatable yet often remain unrecognized and untreated. While a number of effective programs promote higher use of treatments in service delivery settings, particularly primary care practices, these programs are not yet widely implemented. Thus, technology is available to treat this disabling condition, but US health care systems have failed to take full advantage of the technology to reduce personal or societal consequences of depression.

The intervention approach in the study by Wang et al can be characterized as ''building a village'' of health plans, clinicians, and resources that ''surround'' depressed persons with opportunities to learn about and engage in evidence-based care, attending to a careful fit of intervention requirements and context-specific implementation options. This approach has generally proven effective in primary care, and the substantial outreach efforts mirror those in the WE Care study demonstrating that depression treatments are effective for low-income and minority women. In the study by Wang et al telephone managers from the behavioral health company offered counseling and communicated recommendations to clinicians, an extension of their usual role. In the Partners in Care study, primary care nurses expanded their disease management skills to include assessment, education, and follow-up concerning depression. In both studies, patients and clinicians were free to use or not use study resources according to their preferences. Such interventions have the advantage of preserving the naturalistic context of the delivery systems, potentially facilitating the translation of findings into change by example. Interventions in both studies achieved roughly similar outcomes: a 10 percentage-point gain in use of appropriate treatment and in recovery from depression over a year, as well as roughly 2 more weeks of days worked in a year in the study by Wang et al and a month more of days worked over 2 years in Partners in Care.

Depression interventions have many advantages for individuals, their family and friends, employers and society, over and above relief of individual symptoms. As mothers' depression improves following care, for example, their children also enjoy improvements in mental health. The study by Wang et al demonstrates that treatment of depression increases productivity and may reduce economic losses due to depression for employees and employers. If such gains exceed costs of providing the interventions and treatments, there is ''money on the table'' across stakeholders that could be used to pay for interventions. Why then do many individuals with depression endure their illness without care?

One barrier to care is that depression affects motivation and cognition, making it difficult for many individuals with depression to realize they have a need and obtain care without the outreach provided by nurse/care managers. Family members also may fail to identify depression or have knowledge about appropriate care. This suggests that opportunities to improve access to depression care should be embedded within an infrastructure available to potentially depressed persons, such as primary care settings. However, an awareness of the effects of treatment on social costs such as productivity may not provide a strong incentive for clinicians and health plans to improve care, as they do not necessarily face immediate financial consequences from patients' changes in productivity or may not track this outcome. Yet most private health care in the United States is financed through employer-sponsored insurance. Direct contributions to the bottom line of employers offers them an incentive to promote depression care, independent of policy mandates or other motives such as responding to employee demand.

Other stakeholders, including policy makers and the public, may benefit from improved depression care through an increased tax base from employees who work more or an overall improved economy. Yet it is challenging in the US policy environment to use economic gains from one policy sector such as the labor market as leverage to support improved health care, However some policy changes could be implemented to better align the incentives to implement depression care programs across diverse stakeholders and to avoid undermining the goals of such programs, for example by excluding depression treatment from health insurance coverage when changing jobs or insurance based on a recent history of depression treatment in an employer-based depression program. Under such an ill-advised policy, the risk of losing coverage would serve as a major deterrent to seeking care.

The need to coordinate program implementation and policy suggests an expanded concept of ''a village,'' that includes not only wrap-around interventions but coordinated efforts across affected stakeholders. It may be trite that the stakeholder with the most power to influence services delivery for most Americans is the employer, but broader and deeper change in access to depression care may yet require a concerted effort among affected parties to yield programs that address public and self-stigma and to provide access to depression treatments under policies that

facilitate use of such programs and do not penalize individuals for using them. Studies such as that by Wang et al strongly support such integrated solutions.

Exactly how programs to improve depression care are implemented may affect the distribution of benefits—an important issue given evidence of disparities in quality of depression care and the potential for practice-based programs to overcome disparities in depression outcomes. Developers of interventions and policies should consider implications of their design for inclusion of underserved groups who may not seek behavioral health care. Despite the extensive efforts by Wang et al to reach general employees, the majority of persons had already inquired about outpatient care. Learning how to optimize personal and societal gains by improving access to quality depression care across diverse communities through employer, practice, and community-based programs and policy changes is a next agenda for evidence-based action. As a community participant in the Witness for Wellness program recently stated: ''Depression is everybody's business.''

Now, ultimately, despite the economic arguments in favor of parity, it is not a debate about dollars and cents but about lives saved and people restored. Let's work to ensure that those who need access to mental health will get it.

Mr. ANDREWS. Mr. Speaker, it is my privilege at this time to yield 2 minutes to the gentleman from Chicago (Mr. DAVIS), a member of the committee.

Mr. DAVIS of Illinois. Mr. Speaker, I'm convinced that the most widespread and most impactful health issue and problem which we face today is in the area of mental health and mental illness. The numbers of individuals affected are so great until it is more than difficult to get a handle on them, and that is one of the reasons that I rise in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Mr. Speaker, I commend Representatives KENNEDY and RAMSTAD for their leadership in introducing this legislation and shepherding it to the floor.

When we consider the numbers of people who suffer from drug addiction, whose lives are filled with anxiety, depression, fear, and uncertainty, we can readily see that more attention must be paid to our mental health needs. When we see the numbers of people living in shelters, halfway houses, and in many instances under viaducts, abandoned cars, and in the streets, when we see the numbers of people who make up the criminally ill, who hurt, injure, maim and sometimes kill other people because they've never been able to shake their demons who disrupt and plague their lives because they've had no mental health attention or treatment, Mr. Speaker, it is clear to me that this is an idea whose time has come.

I urge passage of this legislation.

Mr. MCKEON. Mr. Speaker, we do have another speaker.

Mr. ANDREWS. I would reserve my time.

Mr. MCKEON. Mr. Speaker, I'm happy to yield at this time to the gentlelady from Oklahoma (Ms. FALLIN) 2 minutes.

Ms. FALLIN. Mr. Speaker, I support bipartisan efforts to bring parity between mental health and medical benefits, but I have a concern, and it's come to my attention, about the mental health parity bill, H.R. 1424.

A Supreme Court decision, Doe v. Bolton, lists mental health as a reason that abortion is allowed for health exceptions.

This bill, as currently written, could be construed to mandate health care coverage for an abortion as part of treatment for a mental health issue such as depression.

As defined by the Court, in their words, ''health of the mother includes all factors, physical, emotional, physiological, familial, and a woman's age, relevant to the well-being of the patient. All these factors may relate to health.''

And furthermore, in testimony by Dr. James McMahon before the House Judiciary Committee in June 1995, he cited 39 partial birth abortions that were performed because of a mother's depression.

Because this issue is unclear, H.R. 1424 lacks a conscious clause applied to this legislation, and there appears to be no protection for an employer to reject health care coverage for such a procedure if they choose to extend mental health coverage to its employees.

Mr. ANDREWS. Mr. Speaker, I yield myself 15 seconds.

I would say that the manuals referred to in this bill make no reference whatsoever to any abortion services as a covered benefit.

At this time, I'd be pleased to demonstrate bipartisan support for this bill and yield 1 minute to the gentleman, my friend from Connecticut, Mr. SHAYS.

Mr. MCKEON. Mr. Speaker, I will add 1½ minutes to demonstrate also bipartisanship.

Mr. SHAYS. Mr. Speaker, I rise in support of the Paul Wellstone Mental Health and Addiction Equity Act. It is reported 50 million adults, 25 percent of the U.S. adult population, suffer from mental disorders or substance abuse disorders; yet, despite the prevalence of mental illness, there continues to be widespread misinformation and ignorance surrounding the condition.

We need to work to destigmatize this illness and ensure those who need treatment have access to care. At the same time, we need to increase biomedical research into the causes of, and treatments for, mental illness.

It is estimated 98 percent of private health insurance plans discriminate against patients seeking treatment for mental illness by requiring higher copayments, allowing fewer doctor visits or days in the hospital, or requiring larger deductibles than imposed on other medical illnesses.

The National Institutes of Mental Health estimates the annual health care costs of untreated mental illness is $70 billion, and data has shown that instituting equal coverage for treatment of mental illness will result in lower overall health care costs.

By requiring insurers who cover mental illnesses to do so at parity with physical illnesses, we will knock down a tremendous barrier to getting the assistance these individuals require.

While I support the underlying bill, I believe we should temporarily hold off for now increasing the Medicaid drug rebate provisions intended to raise revenue to pay for this legislation. Because the Centers for Medicare and Medicaid Services are in the process of developing new regulations based on the Deficit Reduction Act, it's entirely possible Medicaid rebates will be increased administratively. Since this provision was not in the Senate bill, I'm hopeful we will be able to enact mental health parity legislation without this provision.

With this one reservation, I'm particularly pleased to support this legislation, urge its adoption, and congratulate Congressmen RAMSTAD and KENNEDY for all their efforts to help the mentally ill.

Mr. ANDREWS. Mr. Speaker, if I could inquire of my friend from California if he has any further speakers.

Mr. MCKEON. I'm the last speaker.

Mr. ANDREWS. At this point, Mr. Speaker, I would yield to the gentlelady from California who has worked on this issue for many years on the committee, Mrs. DAVIS, for 2 minutes.

Mrs. DAVIS of California. Mr. Speaker, I worked as a social worker before my career in public office, and I've seen firsthand the results when mental illnesses go untreated. Those who develop a severe mental illness can go from having a career and a family to losing everything.

About half our States now have implemented full mental health parity requirements, and these States have learned a very valuable lesson. They've learned that the benefits of ensuring parity are worthwhile.

□ 1800

Far too many people's illnesses, mental illnesses, linger without treatment, triggering physical complications that only result in more costs. So, proper diagnosis and treatment greatly offset these costs and save health care dollars over the long term.

This bill will also help our servicemembers fighting in Iraq and Afghanistan as they transition to civilian life because national barriers to mental health care ripple out to everyone. Post-traumatic stress disorder and other combat-related conditions can take months, if not years, to develop after discharge. Many of these veterans will not have access to VA health facilities and will rely upon private health insurance to obtain treatment.

Finally, and most importantly, this legislation also addresses the stigma

attached to mental health care. It loudly communicates that mental health care is on an equal footing with physical health care.

Mr. Speaker, I give my enthusiastic support to the Paul Wellstone Mental Health and Addiction Equity Act. I thank the sponsors and encourage my colleagues to join me in voting for it today.

Mr. ANDREWS. Mr. Speaker, I would just represent that I am the last speaker on our side for this portion of the debate.

Mr. MCKEON. Mr. Speaker, I yield myself the balance of my time.

I agree with much of what has been said here, because achieving parity between mental health and medical/surgical benefits is a goal that enjoys widespread support, and I support that. Had this bill been negotiated in an inclusive, cooperative fashion, I believe a parity law could quickly be enacted this year, ensuring access to coverage for those who need it.

There was a road map that would have allowed us to forge a consensus bill. On the other side of the Capitol, stakeholders were brought together and given the opportunity to find agreement on these difficult issues. There was give and take by everyone involved, which is how the Senate was able to produce a bill that achieves parity without undue burden on our employer-based health care system. Unfortunately, we're not following that road map. Instead, we're considering a bill that overreaches and in the process puts at risk many fundamental elements of private health insurance plans.

The majority argues that the latest variation of their proposal addresses key concerns. I wish that were true. Unfortunately, the bill we're considering today contains only modest changes that fail to fully resolve concerns about ERISA preemption, costly litigation, coverage mandates, and a host of other concerns.

By giving preferential treatment to mental health benefits over other types of medical coverage, the bill creates a lopsided system that may actually be biased against mental health coverage because some employers may choose to drop their mental health coverage or, worse, all health coverage rather than comply with more burdensome mandates.

Moreover, the list of conditions that would receive mandatory coverage under this bill would be laughable were it not posing such a serious risk to health care coverage for hardworking families. At a time when health care costs are rising, this bill threatens key management tools that have helped keep costs down. And by weakening ERISA preemption, the bill opens the door to increased litigation and a patchwork of confusing requirements and inefficiencies.

Mr. Speaker, there is a better way to provide parity for mental health benefits. The bill that passed the Senate provides a thoughtful, reasonable and a balanced approach that reflects the deliberations of all relevant stakeholders. Representatives HEATHER WILSON, JOHN KLINE and DAVE CAMP sought to offer that proposal today in the hopes that we would move quickly on a consensus proposal that could be signed into law. Their amendment also used a noncontroversial payment offset, unlike H.R. 1424. Unfortunately, as has become the hallmark of the 110th Congress, we were shut out of meaningful debate, and that amendment, along with a number of other improvements to the bill, will not be considered.

I support a balanced approach to mental health parity and, therefore, I cannot support this bill in its current form. I urge my colleagues to vote ''no'' on this bill so that we can take up the consensus legislation that enjoys community and other key stakeholders' support, those who share our commitment to provide equitable benefits that support mental health without jeopardizing our health care system as a whole. I urge a ''no'' vote.

Mr. Speaker, I yield back the balance of my time.

Mr. ANDREWS. Mr. Speaker, I yield myself the balance of the Education and Labor Committee's time.

My friend from California says that mental health parity is a goal that he lauds. Well, it's a goal that we should achieve right here, right now, today, by passing this bill.

We've heard the argument that the bill establishes preferential treatment for people with mental health and substance abuse issues, exactly the opposite of the truth. The bill establishes parity and equal treatment between mental health and substance abuse and physical and surgical benefits.

We've heard the concern that medical management practices that control costs have been taken out of the bill. What is also true, however, is that nothing in present law, nothing in the status quo precludes medical management practices that are useful in offsetting costs. There is nothing that prohibits that.

Finally, we hear that there is a concern that employers confronted with the defined benefit package, with the guaranteed rights of the insured under this will drop coverage. In States that have similar provisions, there is not a shred of empirical evidence that that is the case. Where State laws extend robust protections to mental health and substance abuse benefits, employers have not dropped mental health coverage; in fact, it has expanded.

This is the right time for the right bill. Its cost is minimal, its benefit is great, its support is bipartisan, and its time for passage is now.

I would urge each of our colleagues, Republican and Democrat, to join this bipartisan coalition and vote ''yes'' on the legislation offered by Mr. KENNEDY and Mr. RAMSTAD.

Mr. Speaker, I yield back the balance of the Education and Labor Committee's time.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California.

Mr. STARK. Mr. Speaker, I yield myself 2 minutes.

It's an important day, and we've been working to achieve mental health parity for decades. We finally have a bill before us to achieve that goal for more than 160 million Americans. And as my colleagues know, this bill is named for one of its chief proponents, the late Senator Paul Wellstone of Minnesota, a true champion for all people, especially those suffering from mental illness and addiction disorders.

I would like to recognize the efforts of Paul's son, David Wellstone, who has been commuting from California to lobby Members of Congress to help get this bill enacted. His dad would be proud. Wellstone Action is one of the hundreds of groups supporting this legislation.

Here in the House, our colleague from Minnesota, JIM RAMSTAD, and our colleague from Rhode Island, PATRICK KENNEDY, have been lead advocates. They've done a stunning job getting 273 cosponsors, including 41 Republicans, a real bipartisan feat in this day and age.

Enough of the accolades. The real reason we're bringing forth this bill is to end discrimination in health insurance for people with mental illnesses and addiction disorders. It's not a new concept. We took a baby step back in '96, but it wasn't enough.

This bill does for our constituents what we already receive through the Federal Employees Health Benefit Plan. We also passed the Children's Health and Medicare Protection Act last summer which would extend mental health parity to Medicare beneficiaries. That bill is still pending in the Senate.

Last year, this legislation went through multiple hearings, five markups in three major committees, and the issues are straightforward. Those who oppose true parity may engage in scare tactics or offer red herrings to distract from the underlying issues, but one thing is clear, the bill is better for patients than the Senate bill, yet the cost is almost exactly the same.

The passage of the Paul Wellstone Mental Health and Addiction Equity Act simply finishes the work we have begun. I look forward to negotiating with the Senate so we can get a bill to the President's desk soon. Tens of millions of Americans are counting on us.

I urge support for this overdue legislation.

Mr. CAMP of Michigan. Mr. Speaker, I yield myself such time as I may consume.

We all support the goal of improving patients' access to treatment for mental illnesses. However, this bill represents a flawed approach that will ultimately do more harm for these patients by driving up costs and resulting in few employers actually offering any health care coverage to their employees.

This bill will place an unprecedented number of mandates on insurers and employers, which will increase the costs of health insurance for working Americans. Whether large or small, these costs get passed along to the purchasers of health insurance, employers and employees alike.

Dramatic increases in health care costs have already forced many employers to drop or limit health care coverage. This in turn makes it more difficult for their employees to obtain any health insurance, let alone mental health and substance abuse benefits. The mandates in this bill will only make the situation worse, making health insurance unaffordable for increasing numbers of Americans. This is why employer groups like the Chamber of Commerce, the National Restaurant Association and the National Retail Federation are all strongly opposed to the bill before us today.

There is a better way to achieve the goals of protecting patients and ensuring they get access to the mental health care they need. Senators DOMENICI and KENNEDY have crafted a bipartisan bill that is supported by mental health advocates, employers and insurers, and if that bill were on the floor today, I would vote for it. The Senate bill adopts a more targeted approach to defining covered conditions.

The bill also allows plans to determine the network of providers while maintaining parity for treatment limits and cost sharing. The Senate approach may significantly reduce the potential cost that could be imposed upon employers while still achieving the goal of mental health parity.

The Senate has worked with the mental health community to balance the needs of patients with the ability to provide quality, affordable and accessible health insurance. These compromises led the Senate to unanimously pass their legislation last September. Unfortunately, in order to pay for the costs associated with this bill the majority has also decided to shift costs to every American by increasing Medicaid rebates from pharmaceutical companies and limiting physician ownership in hospitals. Both of these proposals represent the view that bureaucrats, rather than markets, can better govern health care. At the end of the day, price controls and more government regulation increase health care spending and deny patients access to high-quality care.

Whether they want to admit it or not, the majority is increasing health care on every American twice under this bill. As more and more Americans are having difficulty affording health care, we should be looking to expand affordable health care options, not placing more mandates on employers.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, at this time, I am proud to yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. CARNEY).

Mr. CARNEY. Mr. Speaker, I rise today in strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act.

In recent years, many brave Americans serving in the National Guard and Reserves returned home after fighting for our freedom in Iraq and Afghanistan. They return to their civilian jobs and are subject to their private health insurance. The all-too-common tale, however, is that our veterans have witnessed horrors that many cannot even imagine. One in six of these veterans will experience symptoms of post-traumatic stress disorder, or PTSD, that can impair them for many years beyond their homecoming.

Many of these veterans choose to seek treatment at their local VA hospital or clinic. But for some of our veterans in rural areas of our country, like mine, it is far easier to use their private insurance and seek treatment from their local private doctor. Unfortunately, some of these veterans quickly find that PTSD is not covered in their health insurance plan.

Our veterans shouldn't have to travel for hours simply to meet with a qualified mental health professional. H.R. 1424 fixes this injustice and ensures that our veterans have the choice to seek treatment for PTSD through their private insurance plan.

Mr. CAMP of Michigan. Mr. Speaker, at this time I yield 5 minutes to the distinguished gentleman from Minnesota (Mr. RAMSTAD), a distinguished member of the Health Subcommittee.

Mr. RAMSTAD. I thank my friend for yielding.

Mr. Speaker, the issue before us is not just another public policy issue, it's a matter of life or death for 54 million Americans suffering the ravages of mental health and for 22 million Americans suffering from chemical addiction.

Last year alone, 300,000 people were denied access to addiction treatment, most had health insurance, and 33,000 people committed suicide from untreated depression. Over 150,000 of our fellow Americans died as a direct result of chemical addiction.

On top of the tragic loss of lives, Mr. Speaker, untreated addiction and mental illness cost our economy over $550 billion last year. According to the Wall Street Journal, untreated depression alone cost our businesses $70 billion in lost productivity last year.

So it's ludicrous for the opponents to come here and argue that parity will cost businesses $1.5 billion, as my friend from Washington, member of the Rules Committee, did. If you don't believe the Wall Street Journal, certainly those on our side of the aisle, what do you believe? Cost businesses $70 billion, just depression, untreated depression alone.

Mr. Speaker, all the empirical data, including all the actuarial studies, show that equity for mental health and addiction treatment will save literally billions of dollars nationally. At the same time, it will not raise premiums more than two-tenths of 1 percent, according to the Congressional Budget Office. That's our own CBO numbers. So, I don't know where these people are getting these numbers, these inflated cost figures. Pulling them out of thin air is the only thing I can surmise.

The CBO says it will not raise premiums more than two-tenths of 1 percent. In other words, for the price of a cheap cup of coffee per month, several million Americans in health plans can receive treatment for chemical addiction and mental illness. And it's unfortunate, Mr. Speaker, that some opponents of this legislation have misrepresented the costs of enacting parity.

□ 1815

Mr. Speaker, I'm alive and sober today only because of the access I had to treatment back on July 31, 1981, when I woke up in a jail cell in Sioux Falls, South Dakota. I'm living proof that treatment works and recovery is real.

But far too many people in our country don't have the same access to treatment that I had and other Members of Congress have also had. A major barrier for thousands of Americans is insurance discrimination against people in health plans who need treatment for mental illness or chemical addiction.

The legislation that my friend from Rhode Island, PATRICK KENNEDY, who has worked tirelessly on this legislation, who arranged for all 14 field hearings, who has been a real champion, this legislation that we have authored will end the discrimination by prohibiting health insurers from placing discriminatory restrictions on treatment for people with mental illness or addiction. In other words, no more inflatable deductibles or copayments that don't apply to physical diseases. No more limited treatment stays that don't apply to physical diseases. No more discrimination against people with mental illness or chemical addiction.

The Paul Wellstone Mental Health and Addiction Equity Act simply provides equal treatment for diseases of the brain and the body. This legislation provides people in health plans with the same exact coverage that we as Members of Congress have and other Federal employees as well.

By the way, some of the exaggeration, some of the red herrings as to the use of the Diagnostic and Statistical Manual IV are just beyond belief. The red herrings presented by opponents, caffeine addiction, sibling rivalry, jet lag, would not be subject to treatment because insurance plans can use ''medical necessity'' requirements. So let's not use bogus red herring arguments. Let's come with intellectually honest arguments if you're against this legislation.

Also, the DSM-IV is used for Medicare, Medicaid, and veterans health care. I wonder how many of you can go home and say, look, it's good enough

for Members of Congress but it's not good enough for you, constituents. I don't think anybody in this body would dare do that nor should we. If it's good enough for Members of Congress, it's good enough for the American people.

Mr. Speaker, PATRICK KENNEDY and I have traveled the country from one end to the other, holding 14 field hearings. We've heard literally hundreds of stories of human suffering, broken families, tragic deaths, shattered dreams all because of insurance companies not providing access to adequate treatment for mental illness and addiction. I don't have time, Mr. Speaker, to recite some of these horror stories, but PATRICK and I could share hundreds and hundreds of horror stories caused by discrimination in treatment for mentally ill and addicted people that we heard in these 14 States.

Mr. Speaker, it's time to end the discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory barriers to treatment. It's time to pass the Paul Wellstone Mental Health and Addiction Equity Act. The American people, Mr. Speaker, cannot wait any longer.

Mr. STARK. Mr. Speaker, I am pleased to yield 2½ minutes to the distinguished gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Mr. Speaker, this day has been many years in the making. This mental health parity will be a signature jewel in the crown of the 110th Congress. This legislation reflects our deepest values as Americans.

I want to thank Congressman KENNEDY and Congressman RAMSTAD for your long labors in making real mental health parity a reality. Families all over America will be forever indebted to you.

I have long been a supporter of affordable, accessible, quality health care for every American for both physical and mental illnesses. As a member of the Jersey legislature, I worked for parity legislation that finally came to fruition in 1999. Like the 1996 Federal parity law, the coverage was not complete. Advocates in Jersey continue the fight to ensure real and complete coverage parity.

Today, at long last, this House will take one step closer to making that a reality by passing H.R. 1424, the Mental Health and Addiction Equity Act. Thank you, both of you.

For the first time, this legislation will eliminate inequitable treatment limits and end the imposition of financial requirements on mental health benefits which are not similarly imposed on comparable physical ailments. These two policies are considered to be essential steps toward ending coverage discrimination against individuals with mental illness.

To be clear, this legislation does not mandate insurers or group health plans to provide any mental health coverage at all. This legislation will ensure coverage of the same mental illnesses and addiction disorders available to Members of Congress and 8.5 million other Federal employees. Isn't that a breakthrough.

While opponents of this insist that parity will bankrupt the health care system, research has shown that there's no significant cost increase whatsoever. The Congressional Budget Office has estimated a minuscule impact on premiums for the mental health parity bill, just two-tenths of 1 percent.

This must be passed, both sides of the aisle, and America will benefit.

Mr. CAMP of Michigan. Mr. Speaker, at this time I yield 4 minutes to the distinguished gentleman from Texas (Mr. SAM JOHNSON), a member of the Ways and Means Committee and the Health Subcommittee.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, I come to the floor today proud to say I've been looking to the issue of mental health parity since 2002. In March of that year, I chaired the subcommittee that held the very first House hearing on that topic. I heard back then and have continued to hear over the years the concerns from mental health advocates, employers, and benefit managers about what effect parity may have on everyone's goal of providing quality health care to more Americans. So I come to the floor today disappointed that we are debating a bill that I cannot support.

Unfortunately, the majority has decided that politics should trump policy; that instead of bringing a bill to the floor that has the support of all the stakeholders in this debate, a bill the President has said he would sign into law, and a bill the Senate passed by unanimous consent, we're debating a bill that will only delay action on this very important issue.

There are real problems with the bill before us today. The first is the heavy-handed list of mandates. This bill would say to employers and insurance companies, if you decide to include mental health benefits in your health insurance package, you are forced to cover anything and everything related to mental health.

This is a requirement that doesn't exist in any other sector of the insurance industry, and I believe it would have the unintended consequence, in spite of what our opposition says, of forcing employers and companies to decide not to offer mental health benefits at all. This, of course, is not the goal we're striving to achieve today.

This bill also pays for mental health parity with a provision that would have a devastating effect on communities across the Nation. This provision would hurt every physician-owned hospital in this country, and that includes specialty hospitals, long-term acute care facilities, physician-owned full service hospitals, and patient rehabilitation facilities and others.

Physician-owned hospitals serve as an integral part of the health care system in this country. They deliver efficient, high-quality care to their patients and are a benefit to any community. These facilities across the country routinely are recognized nationally for their superior care.

In fact, just last month a hospital in my district, Baylor Health Care System, received the National Quality Award from the National Quality Forum. This award recognizes exemplary health care organizations who are role models for achieving meaningful and sustainable quality improvement in health care.

However, if this provision becomes law, this exemplary hospital would be forced to suffer serious consequences, like reducing patient care.

We all support the goal of equal access to mental health benefits; however, it should not be paid for by sacrificing facilities that bring quality health care to more Americans. Physician-owned hospitals are on the front lines of reforming our health care system, and they shouldn't be punished for the inroads they are making.

This provision will prohibit any new facility from being built as well as deny Medicare provider numbers to any facility currently under construction. It also caps the percentage of physician ownership in existing hospitals. No one facility can have more than 40 percent physician ownership, and no one doctor can own more than 2 percent of a facility. It puts the Federal Government in charge of deciding whether or not these facilities need to expand and help respond to the needs of the community.

There have been a number of studies that have shown specialty hospitals have an overall positive effect over general acute care hospitals.

Today is the day to stand up for innovation and stop taking the funding from the specialty hospitals, Mr. STARK.

Mr. STARK. Mr. Speaker, at this time I am pleased to yield 1 minute to the distinguished gentleman from Minnesota (Mr. WALZ).

Mr. WALZ of Minnesota. I thank the chairman for yielding.

Mr. Speaker, I rise in strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act.

I'd like to thank and recognize my two colleagues and friends who have led this fight with tenaciousness and with integrity for so many years, Congressman KENNEDY, and my friend and fellow Minnesotan, Congressman RAMSTAD. The two of you represent the best that this institution has to offer, and I thank you. You carried on the fight that was started so many years ago by our late Senator from Minnesota, Paul Wellstone, and you've done so in such an admirable fashion. I can't tell you how proud I am to see this come to the floor.

One of Senator Wellstone's qualities was one that you've exemplified. He

stood up and he fought for what he believed in. It didn't matter what the political implications were. It didn't matter what others said. He steadfastly believed that discrimination against people because of mental illness or addiction was absolutely wrong and the antithesis of what America stood for.

Senator Wellstone represented our State of Minnesota, and due to his work, Congressman RAMSTAD's work, Congressman KENNEDY's work, Minnesota has one of the strongest parity acts in the Nation, and it works. If we can do it there, we can do it in this Congress.

I would urge my colleagues to vote for this bill, not accept anything less, not the Senate version, not something from the White House, not a motion to recommit, not a smokescreen. This is the time to get this right the first time. Do the right thing. Pass this piece of legislation. This country will be better for it.

□ 1830

Mr. CAMP of Michigan. At this time I reserve the balance of my time.

Mr. STARK. Mr. Speaker, at this time I am happy to yield 2 minutes to the distinguished gentleman from Connecticut (Mr. LARSON).

Mr. LARSON of Connecticut. Mr. Speaker, I thank the distinguished Chair, and rise to associate myself with his remarks.

What a remarkable afternoon this has been. What a remarkable journey of two of our colleagues. I rise today to support them for what they have done in the old-fashioned democratic way, reaching out across this country, holding hearings, and bringing back to this body a piece of legislation long overdue. I commend Representative RAMSTAD and Representative KENNEDY. Their work has been extraordinary.

President Kennedy once said that communities reveal an awful lot about themselves in the memorials they create, the people that they honor. This body is about to reveal an awful lot about itself on the legislation we are about to vote on. Two of our colleagues revealed so much about themselves in an effort to bring forth the plight of others less fortunate than they, and unable to be here on this floor to speak. That is the crowning glory of this great democracy that we all participate in.

Patrick Kennedy had it right. This is a certain right. This is a civil right. This is something that goes beyond parity and speaks to the very essence of equality in what we stand for. And two of our colleagues have demonstrated the way to do that beyond the Chambers, beyond the Beltway, and out to the people where it really matters. Thank you so much for bringing their cause here today.

Mr. CAMP of Michigan. I reserve the balance of my time.

Mr. STARK. Mr. Speaker, at this time I am pleased to yield 2 minutes to the distinguished gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank my friend, Chairman STARK, for yielding.

Mr. Speaker, I rise today to give my full support to H.R. 1424, the Paul Wellstone Mental Health Parity Act. I want to thank my colleagues, my very good friends, Mr. KENNEDY and Mr. RAMSTAD, for their leadership on this important issue, for having the courage to stand up, to speak up, to speak out to take the leadership and bring this bill before us today.

Today, we win a battle in the ongoing struggle against discrimination. Discrimination against mental illness and addiction is wrong. It is dead wrong. Today, we end that discrimination in health insurance. I believe that health care is a right and not a privilege. Until we can provide real and meaningful health coverage to all Americans, we must take each step as it comes to expand coverage. So, today we take an important step, a necessary step in that direction by requiring parity in insurance coverage.

I have fought long and hard to end discrimination in this Nation, and we have made some real progress. But people suffering from mental illness and addiction have been left out and left behind, and it's time for us to do what is right when they are told that their illness is not covered by their insurance. That discrimination must end, and it must end now.

Mental health parity is a matter of fairness, of equality, and it is the right thing to do. The time is always right to do right.

Mr. CAMP of Michigan. I reserve the balance of my time.

Mr. STARK. Mr. Speaker, could I find out how much time remains on both sides.

The SPEAKER pro tempore. Both sides have 8½ minutes remaining.

Mr. STARK. Mr. Speaker, at this time I am happy to recognize the distinguished gentleman from Maryland (Mr. VAN HOLLEN) for 2 minutes, a member of the Ways and Means Committee.

Mr. VAN HOLLEN. I thank my colleague.

Mr. Speaker, I rise in strong support of this long overdue bipartisan legislation, and I want to commend and thank our colleagues, PATRICK KENNEDY and JIM RAMSTAD, for their leadership, their passion, and their perseverance on this very important issue that is so important to millions of Americans around this country.

Last year, they traveled across this great land, holding a series of field hearings, listening to Americans in communities across the Nation, people from every walk of life. I had the privilege of hosting one of those hearings in my congressional district. The message from that hearing, as with the other hearings from around the country, was very clear, Congress needs to end insurance discrimination in mental health care. Both common sense and simple fairness require that mental health diseases be treated on an equal footing with other health conditions.

According to the National Institute of Mental Health, an estimated 26 percent of Americans suffer from a diagnosable mental disorder in any given year, and approximately 6 percent of our fellow Americans suffer from serious mental illness. Mental disorders are the leading cause of disability for individuals between the ages of 15 and 44. The good news is the science tells us that treatment works. The sad truth is that, for most Americans, health insurance coverage does not now cover the full range of their needs.

We know that for years, for years, employer-provided health care set stricter treatment limits and imposed higher out-of-pocket costs for mental health care. Congress took an important step in 1996 to correct that inequity through the Mental Health Parity Act. But problems remain, and that is the reason we have this very important legislation before us, because insurance companies were setting rigid, arbitrary caps on how they cover mental health. This legislation will finally stop those practices.

Mr. Speaker, Members of Congress have good health care coverage and mental health coverage. Let's give the same thing to the American people.

Mr. CAMP of Michigan. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California (Mr. HERGER), a member of the Ways and Means Committee.

Mr. HERGER. Mr. Speaker, I would like to encourage every Member of Congress to ask their constituents one simple question: Are your health insurance premiums high enough yet? Because this bill will make them even higher. We all want to improve access to mental health treatment. But the legislation before us could force some employers to drop mental health benefits altogether. Under this bill, plans are actually prohibited from covering treatment for depression, or potentially even a program to help someone quit smoking, unless they agree to cover literally everything in the book.

I am especially concerned by the offset that effectively bans physician investment in hospitals. I am concerned that this provision could have a devastating impact on access to high quality health care. For example, there are just two hospitals in the city of Redding, California, in my northern California district. One of them nearly shut down a few years ago. It was bought by a company that specializes in turning around failing hospitals.

Part of their strategy was to give the physicians who work at the hospital a partial ownership stake. They were successful. As a result, a vital community hospital is still open in a largely underserved area. This so-called ''offset'' would subject it to crippling new regulations, and it could doom other struggling hospitals to closure.

Vote ''no'' on this legislation.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. EMANUEL). Pending that, I yield myself 15 seconds to remind the distinguished gentleman from California that the hospital that closed in Redding was the one that killed 167 people by unnecessary cardiac procedures, and we were glad to be rid of it.

Mr. EMANUEL. I thank my friend from California for the time.

When I worked in the White House in 1996, we took two important steps on dealing with mental health parity. The first was signing the mental health parity legislation in 1996. That was referred to earlier. The second was also signing the executive order that ensured that government workers, Members of Congress and their staff, as well as other government workers, also had mental health parity in their health care. Some would think we are a little crazy for being in this job, but now we have got health care coverage for it.

The fact of what this legislation does is provide for the taxpayers in America and make sure that they have the same access to the same type of health care that we have. It's that simple. When we did the first bill, the same people that were opposed to this bill, the insurance companies, said it would ruin the health care system. It didn't happen. The same insurance companies that are in the Federal employee system said they couldn't do what the executive order told them they had to do. They did it.

Every time you try to make a little more reform to have a little more coverage, the insurance companies tell you that you can't do it. We accomplished it, and we accomplished it by doing right by the American people.

The prior speaker mentioned that everybody is for covering mental health coverage, or for having mental health coverage, except for when it comes to covering mental health coverage. You can't be for it and then against it. Everybody was for an increase in the minimum wage, except for when you wanted to vote for it, they weren't voting for it. Everybody thought it was a good idea to increase Pell Grants, except for when it came to vote to increase Pell Grants.

Well, here we are going to do this. You can't just say you're for mental health parity and then vote against it. This is the legislation. It builds on what we did in 1996 and 1999, and brings the type of reforms that are necessary. This is an illness, and these illnesses affect everybody's families, everybody's families, and it makes sure that there is one set of rules to the road when it comes to health care coverage.

I appreciate the time, and it's time that we have this type of legislation on the floor.

Mr. CAMP of Michigan. At this time we have no further speakers, so I reserve my time, except to close.

Mr. STARK. Mr. Speaker, at this time I am happy to yield 1 minute to the distinguished gentleman from Pennsylvania (Mr. PATRICK J. MURPHY).

Mr. PATRICK J. MURPHY of Pennsylvania. I thank my colleagues for taking the fight and leading the fight here.

Mr. Speaker, I rise today on behalf of a teenager from Bensalem, Pennsylvania, for whom mental health care came too late. I rise in favor of a health care system that works for those in need. This legislation not only promotes fairness for those with mental illness, it also will not preempt stronger State laws, laws such as Pennsylvania's Act 106, which has saved countless lives.

I stand with the Republican State Representative from my district, Gene DiGirolamo, as we fight together to preserve these critical laws in conference. Mr. DiGirolamo of Bensalem is a leading advocate for mental health parity, and has worked tirelessly for health care laws that are fair and just.

Mr. Speaker, this bill is bipartisan and long overdue. I urge my colleagues to join us in voting for it.

Mr. CAMP of Michigan. I continue to reserve.

Mr. STARK. Mr. Speaker, do I have the right to close this section?

Then I would reserve the balance of my time.

The SPEAKER pro tempore. Mr. PALLONE had reserved 2 minutes, and he will be the final speaker. But in this section, the gentleman from California has the right to close.

Mr. CAMP of Michigan. I will be our final speaker on this side, Mr. Speaker.

This debate is not really about who's for or against mental health parity, it's about doing mental health parity in the right way. The Senate unanimously passed a mental health parity bill last year, and there, Senators KENNEDY, DOMENICI and ENZI worked in a bipartisan way and brought all affected parties together to reach a compromise that mental health groups, employers and health plans fully support.

What has really not been answered in the debate today, and I don't fully understand, is why put the entire DSM-IV manual in statute. It's a diagnostic code. It's not for coverage decisions on health benefits. That question has never really been fully answered.

Let's do the sensible thing. Let's vote this bill down and adopt the Senate bill. We can have a mental health parity bill on the President's desk by the end of the month if we followed this procedure. So I urge my colleagues to vote ''no'' on this bill.

I yield back the balance of my time.

□ 1845

Mr. STARK. Mr. Speaker, I yield myself the balance of my time just to suggest that while costs have been an issue, basically the Senate bill, as I understand it, would be the preferred vehicle for the opposition to this bill, and I would like to just remind my colleagues that the Senate bill and the House bill cost the taxpayers the same amount of money. There is no cost difference between the Senate bill and the House bill.

We are talking about a cost to employers, if they pay the entire cost of insurance, of 2 cents out of every $10, hardly a phenomenal cost when you think that the savings in productivity, human lives, and the billions of dollars that we would save in lost time and additional costs from the results of addiction and mental illness would be a bonus for which we don't get scored under our scoring procedures.

This is a bill that was first introduced in the Ways and Means Committee, as I recall, almost 20 years ago. I wasn't able to do much with it in 20 years, but my distinguished friends PATRICK KENNEDY and JIM RAMSTAD have been able to do it, and I just want to repeat how proud I am of their tireless work.

I hope that we will end the day today for the under-65 population of this country with mental health parity, and that we could come back again later this year or next year to finish this for us older guys in Medicare, so that we can also extend parity for the rest of the Americans.

I want to thank all the staffs who have worked so hard, my colleagues on the Health Subcommittee of Ways and Means, my colleagues on Energy and Commerce, my colleagues on Education and Labor. This went through three committees, a feat in itself in this Congress. I think it is a bill that the time has come. We can set aside what minor differences there are, go and negotiate with the Senate for the final bill, and I look forward to its passage.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. The gentleman from New Jersey, Mr. PALLONE, controls the remaining 2 minutes.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just want to also thank the two sponsors of this legislation, Mr. KENNEDY and Mr. RAMSTAD. If any of you had been in Trenton, New Jersey, the day when Mr. KENNEDY held a hearing, to see the compassion that he brought to the hearing, to hear him tell his personal story, to see those who are advocates for the bill in my State to show up and basically explain why the type of discrimination that exists now with regard to mental health coverage should not continue.

I think Mr. KENNEDY said on the floor today that this is a civil rights issue, and that is true. People may doubt that a lot of discrimination continues to exist about mental illness, and certainly we have come a long way, there is no question about that, but the fact of the matter is that the discrimination continues. And although we have made some progress in terms of the Federal law, and even different States have passed legislation that is somewhat similar to this, the bottom line is

that we don't have absolute equality or equity at this point, and we need to make sure that if there is going to be mental health coverage, it covers all types of mental health illnesses as well as substance addiction. In addition to that, we want to make sure that the same is true, whether you are in or out of the health care network.

These two gentlemen, my colleagues Mr. RAMSTAD and Mr. KENNEDY, have been working on this bill for such a long time, and it really is a tribute to them and to Paul Wellstone that we are about to pass this bill. We commit, myself and the other chairmen of our respective committees, that we will not only pass this, but we will make sure that we do a bill that we can conference between the two Houses and get it to the President and hopefully get him to sign it before the end of this session.

Mr. ELLSWORTH. Mr. Speaker, I rise in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. The passage of this bill today is an important step forward in the effort to ensure every American has access to quality mental health care services.

Access to quality, affordable mental health care is just as important as access to traditional health care for Americans struggling with psychological problems. For decades, America has led the world in developing and implementing mental health diagnosis and treatment methods. Unfortunately, while American hospitals, doctors, and counselors provide the best mental health care in the world, many Americans are left without access to the benefits of that system. Too often, cost prohibits people from obtaining adequate coverage and seeking care when they need it.

This bill makes important advances in addressing this problem for Americans with private health insurance. H.R. 1424 will expand access to mental health care and services for Americans with private health insurance, requiring plans to make mental health copayments, deductibles, and other benefits equal to benefits offered for traditional, physical health care. I believe this bill is an important step in breaking down the barrier to treatment many Americans with mental health problems face when they try to improve their lives, and I urge my colleagues to support it.

While I am a strong supporter of the underlying legislation, I would like to express my concern with one of the offsets used to pay for the bill's costs. The Medicaid prescription drug rebate has proven to be an important tool in ensuring access to the best pharmaceutical drugs for low-income Americans. Currently, prescription drug producers already pay a significant rebate in order to participate in Medicaid, and this bill would increase that rebate by almost one third. I am concerned that further expanding this rebate could have a negative impact on research and development of the next generation of treatments. Congress needs to ensure it provides increased access to mental health services without jeopardizing future pharmaceutical breakthroughs.

I will continue to support this bill and encourage my colleagues to do the same. However, as this bill advances to conference with the Senate, I hope that the final product we send to the President will not contain an overly burdensome increase in the Medicaid rebate.

MR. BACA. Mr. Speaker, I rise today in strong support of civil rights and the passage of H.R. 1484, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

This bill is aimed at eliminating discriminatory provisions in mental health. With this bill addiction treatments are provided on par with treatment for other medical illnesses and conditions, such as diabetes, asthma and high blood pressure.

Currently, many families are facing hurdles and obstacles in obtaining quality care for mental illness and addiction disorders.

Over 57 million Americans suffer from a form of a mental health disorder and more than 26 million from a chemical addition. Our early intervention services for mental health and addiction are behind other medical conditions.

This is discrimination; this is not the American way.

In my District alone, we are facing an alarming methamphetamine-use crisis, these patients often require professional help.

Mental health must be recognized as equal to other health conditions and illnesses. The stigma must be removed so more people will be able to seek professional help and our loved ones will be able to live healthy and productive lives.

These are real diseases, and those affected by them deserve coverage. We are living in different times now and we need to pay closer attention to the mental health needs of our families.

For example, the recent school shootings are evidence of where counseling and treatment may have prevented these tragedies, yet stigma and lack affordability of mental health services stood in the way.

I urge my colleagues to support mental health parity and vote in favor of H.R. 1424.

Mr. UDALL of Colorado. Mr. Speaker, I rise today in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. This bill moves forward the important principles that mental health deserves fair and equal recognition in our health care financing system and that individuals afflicted with mental health disorders deserve no less a chance at recovery than those afflicted with physical disorders.

These principles do not exist for their own sake, and there are plenty of practical reasons that mental health coverage should be equal to that of other types of health coverage. For example, the Journal of the American Medical Association estimates that employers lose as much as $31 billion per year in productivity costs associated with having depressed workers. The story is much the same for alcohol-related illnesses and certainly for suicide. Even if these economic realities did not exist, there remains no scientific justification for treating mental health as separate and inferior to physical health.

Many attribute the historical disparities between the treatment of mental health and physical health to stigmas about the realness of mental health disorders and the credibility of those who claim to have them. If this is true, surely our scientific and health care communities have moved us beyond those stigmas and shown that mental health not only exists, but is as important to one's day to day life as any physical condition. It is time that our laws and our health care financing system caught up to our scientific knowledge in this important respect.

H.R. 1424 will move us in that direction. If passed, it will bring this aspect of our private health insurance system in line with what has worked for Medicare, Medicaid, the Veterans Administration, and the Federal Employees Health Benefits Program—the very same health program available to members of Congress. This is not a mandate. Employer-based health care plans will not be required to offer mental health benefits, but those group plans with 51 or more employees who do offer mental health benefits will be required to provide coverage that is no less substantial than the coverage provided for physical health. This is sound policy, and ensures that those afflicted with mental health disorders can afford the care they need to lead productive, happy, healthy lives.

I am aware that there are some differences between this bill and the similar bill that passed the Senate last year. Some opponents of the House version, I think, have legitimate concerns about the effects of basing coverage on the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV). The instances in which plans and states have adhered to the DSM–IV have not yielded the problems with overuse and treatment for the ''worried well'' that opponents predict, but the possibility that these problems could occur, I think, is strong enough that these differences should be addressed before the bill becomes law. I am hopeful that ongoing discussions between the House and the Senate will produce a bill that addresses these concerns and finds a suitable compromise.

I will vote for this bill because I believe that moving it forward in the legislative process is one more important step toward the final goal of instituting equity between physical and mental health coverage, a goal I hope can be achieved this year.

Mr. HULSHOF. Mr. Speaker, I am very glad that we are taking up mental health parity today. I support mental health and substance abuse parity, as does most of this body. But there are a few details of this bill I would like to change to ensure that true parity be the final result of the legislation before us.

But because this is brought up under a closed rule, these vital changes cannot be made, thus I will oppose this bill.

Let me add at the outset that I have only the utmost respect for my friend and fellow Health Subcommittee member JIM RAMSTAD. He is a champion on this issue, and the tenants of mental health parity that most here support are in no-small-part thanks to his intelligent, passionate advocacy. I thank the gentleman for that example and his service to this institution.

September 18, the Senate voice voted S. 558, legislation that was the product of input and agreement between mental health advocates, policy experts, health providers, employers, and authoring legislators.

I am concerned that in passing the language in this bill, this House will be marginalizing itself—that in passing a bill with no real hopes of adoption by the other body this body will be seen as out-of-touch, a secondary player, and at worst could hold up much needed mental health legislation.

I would like to highlight two key differences between the House and Senate bills, using the

language from the Senate compromise bill—the codification of the DSM–IV, Diagnostic Statistical Manual, and protection of Medical Management.

DSM

I proposed two amendments at the Ways and Means Committee that would have won my vote there and here on the floor and would move this bill more quickly through a House-Senate conference and to the President's desk for signing.

The first issue, this legislation creates a broad new mandate by codifying usage of the DSM–4 (DSM–IV).

H.R. 1424 imposes a broad mandate to cover all mental illnesses listed in the DSM–IV Manual. DSM is the Diagnostic Statistical Manual that provides diagnostic criteria and codes for billing health plans.

Health Plans will be required to provide coverage for all the conditions listed in DSM–IV—conditions such as caffeine withdrawal and jet lag are included, as other speakers have and will discuss. This is simply a benefits mandate.

The bill exceeds the stated objective of achieving "parity" by requiring coverage of all conditions in the diagnostic manual for mental health and substance abuse disorders if a plan decides to cover any mental health or substance abuse conditions at all. No similar Federal requirement applies to any other category of benefits.

Currently, there is no Federal definition of the scope of medical/surgical benefits that plans must offer. Therefore, this is NOT true parity.

MEDICAL MANAGEMENT

The House bill contains no provision to protect medical management practices. These can include such things as coordinated disease management, care management initiatives, health coaching, and patient support tools to improve the quality and accessibility of mental health benefits.

The use of medical management allows plans to provide the right course of treatment and avoid expending resources on ineffective or unproven treatments.

The Senate bill would protect plans ability to manage mental health benefits in this way, even if such management is more intensive than the management of other types of medical services.

The reason FEHB plans have been able to keep their costs down is because they are allowed to offer medical management programs to determine whether a treatment is medically necessary or not.

In fact, the principal investigator who evaluated parity for Federal employees stated in his testimony to the Energy and Commerce Committee that "these findings suggest that parity of coverage of mental health and substance abuse services, when coupled with management of care, is feasible . . ."

If enacted, H.R. 1424 will limit the ability of group health plans to apply a full range of medical management tools—including the use of provider networks and contracting—tools essential in controlling costs and ensuring quality.

GENETIC INFORMATION NON-DISCRIMINATION ACT

I would like to make one other point on the attachment of the Genetic Information Non-Discrimination Act to H.R. 1424, legislation I supported out of Committee.

But at Ways and Means we fixed language protecting those who donate their time and selves for clinical research, but this final language is not comprehensive.

I am concerned with the definitions of genetic testing/services, that they fully include protection for those going into clinical research. An example: John's employer learns that John is signing up for clinical research and fires him or his insurer drops his policy. The bill now says "genetic services received pursuant to clinical research." So, John isn't protected because he has not had a genetic test or service, he's only signed up to do it. Or maybe the employer discovered that John is interested in participating and fires him.

The services themselves are protected, which is good. However, the definition is missing the protection of the ability to participate in clinical research. The Ways and Means Committee passed language protecting this, and I hope that this language can be perfected at conference with the Senate to protect all clinical research participants.

Mr. SMITH of Texas. Mr. Speaker, I support better health care being made available for the mentally ill. Americans should have the freedom to choose health care plans that offer mental health benefits.

I also support the passage of H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007," because this legislation represents a step forward in the mental health care debate.

However, I believe the House bill goes too far by limiting physicians' ability to refer patients to physician-owned hospitals. Physician-owned hospitals play an important role in providing high quality care to patients. These facilities should not be penalized for offering accessible health care to so many individuals.

In addition, this legislation requires any plan that provides mental health or substance-related disorder benefits to offer coverage for all disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV). The list of disorders encompassed by this legislation is too broad and could be used by some individuals to take advantage of the health care system.

H.R. 1424 also will not allow employers to have discretion over the benefit coverage decisions for their employees. It instead imposes a mandate that requires employers to cover all conditions listed in the DSM–IV. This mandate likely will increase health insurance costs.

I am hopeful that if this legislation goes to a Conference Committee, the House will adopt much of the language contained in the Senate version of the bill, S. 558, the "Mental Health Parity Act." The Senate bill represents a compromise between the mental health and business communities.

The Senate legislation provides employer discretion by allowing employers to determine which mental health conditions should be covered under their plan and does not include language that penalizes physician-owned hospitals.

I look forward to continuing to work with my colleagues on this important issue and to making sure we have an improved bill at the end of the process.

Mrs. BACHMANN. Mr. Speaker, today we are debating a bill which addresses an issue that is near and dear to my heart: helping those with mental health disorders.

As the wife of a clinical therapist, I have seen the many challenges that people who have mental health disorders face day after day.

These are very real impairments—but through counseling and appropriate treatments, real breakthroughs can be made.

We can help those individuals who suffer, as well as their families and our overall society.

But I have serious concerns about the scope of this legislation and the impact it will have on the affordability of health insurance for all Americans.

By mandating that group health plans offer the same financial benefit structure for both mental and physical disorders, the cost of insurance will increase across the board—and with accessibility of health care services and the affordability of health care coverage so paramount a concern for families across the country.

The Congressional Budget Office has estimated that the cost of these mandates in the private insurance market will total $3 billion annually by 2012.

This will inevitably set up a cycle of increasing costs on employers offering health insurance and thus increasing costs for employees seeking to obtain coverage.

These mandates may even have an adverse affect on access to mental health coverage at all.

My colleagues in support of the bill have stressed that it does nothing to require employers to offer coverage of mental health services—it only mandates what this coverage must include on those who choose to offer mental health coverage.

But it is not hard to imagine that many employers who are frustrated with the increased costs the bill will impose on them will simply drop mental health coverage altogether.

That, of course, would be counterproductive to the intent of the bill.

In fact, it would hurt the very people the bill purports to help.

Mr. Speaker, the cost of health care is at perhaps an all time high.

Between 2000 and 2006, premiums for family coverage have increased by 87 percent, making the average premium families' paid last year $12,106.

This is not the time to make coverage less affordable.

Though I appreciate my colleagues' good intentions, the negative impact this bill would have on our overall health care market is too serious to ignore and I must oppose it.

Mr. CONYERS. Mr. Speaker, I rise to voice my strong support for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, which requires equity in the provision of mental health and substance-related disorder benefits under group health plans. This much needed legislation would finally provide for true mental health insurance parity, offering mental health and substance-abuse benefits on par with medical and surgical benefits, ending discrimination against patients seeking treatment for psychiatric disorders.

Mental illnesses have a devastating affect on our nation. According to a 2005 Harvard study, over 35 million Americans suffer from a moderate or serious mental disorder in any given year. Societal costs, such as loss of productivity and the burden on family caregivers, total $113 billion annually. As well, the President's New Freedom Commission on Mental Health reported in 2003 that mental illnesses constitute the leading cause of disability in the United States; the Commission noted that half

of those who need mental health treatment in this country do not receive it.

The treatment of mental illness works. Unfortunately, only those who are able to access care can benefit from it. Most mental disorders are chronic, ongoing illnesses that require consistent and persistent treatment in order to achieve remission. It would seem unconscionable to limit the number of times a cancer patient sees their oncologist for treatment; those suffering from severe psychiatric illness should not be held to a lesser standard of care.

Despite disinformation put forth by some of my colleagues today, the concept of mental health insurance parity is not a new one. In fact, as members of Congress, we all enjoy the benefits of mental health parity that our constituents are deprived of. The Federal Employees Health Benefits (FEHB) Program has offered mental health and substance-abuse benefits on a par with general medical benefits since 2001. A convincing study of the FEHB program published by the New England Journal of Medicine in 2006 proves that the implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

Mr. Speaker, the inequity of coverage with regard to mental health and substance abuse treatment benefits is tantamount to discrimination against the mentally ill, and it reinforces the strategy of insurance companies to deny care rather than provide care. It is our duty to end this intolerable discrimination against the mentally ill, and pass H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Mr. HOLT. Mr. Speaker, it will be a landmark day when we realize that health is not just about fixing broken bones. It's about having a healthy, complete individual from head to toe. Millions of Americans suffer from mental illness of some form, conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Mental illnesses strain families and can contribute to lost productivity, unemployment, substance abuse, homelessness, or suicide. Few Americans are untouched by it. No one is immune.

Prompt and comprehensive treatment can reduce enormously these effects, but insurance companies—including government plans like Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—frequently impose limits on coverage for mental health that are not imposed on traditional medical and surgical care. Already this year, Congress has worked to address these inequalities in the federal health programs.

Today, the House of Representatives is taking a significant step toward finally ending the insurance discrimination that has existed for decades against people with mental illness.

Representative PATRICK KENNEDY and Representative JIM RAMSTAD deserve credit for their strong leadership on the Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, which I am proud to cosponsor along with more than 270 of my colleagues. This much needed legislation would require insurance companies to provide benefits for mental health and substance abuse treatment equal to those provided for physical medical treatment.

The Paul Wellstone Mental Health and Addiction Equity Act would require that all Diagnostic and Statistical Manual of Mental Disorders, DSM–IV, illnesses be covered, rather than letting insurance companies determine their own scope of coverage. This is the same coverage requirements that we as Members of Congress receive under our federal employee health plan, and our constituents deserve no less coverage.

The American Psychological Association, which publishes DSM–IV, reports that lack of insurance coverage (87 percent) and cost (81 percent) are the leading factors for individuals not seeking mental health services. The Paul Wellstone Mental Health and Addiction Equity Act would solve both of these problems.

Additionally, unlike the bill working through the Senate, H.R. 1424 would not preempt state law. This is very important for the residents of my home state of New Jersey and others who already have mental health parity laws on the books. For good reason these states worry that they might be forced to reduce their coverage requirements.

We know that mental illness is treatable, yet because one third of the people affected do not receive needed treatments, mental illness remains a leading cause of disability and premature death. According to the World Health Organization, the costs related to untreated mental illness are $147 billion each year in the United States. Those who oppose the legislation thinking it is too expensive should note this cost.

Yet, an analysis of the Paul Wellstone Mental Health and Addiction Equity Act indicates it would result in an increase of less than one percent premiums and would reduce out-of-pocket costs by 18 percent. Further, a recent article in the Journal of American Medical Association, JAMA, indicates that employers who actively encourage their employees to use mental health services actually experienced an increase in hours worked and productivity gains.

Ultimately, despite the economic arguments in favor of parity, it is not a debate about dollars and cents, but about lives saved and people restored. I recently received a letter from a constituent who is a corporate human resource director. She did not write me in that capacity, however. Instead, she wrote me ''as the sister of a beloved brother who committed suicide one day after his in-patient mental health care benefit 'ran-out'.'' She understood and related to me not only the human resources concerns, but also and especially, the true cost of mental health and the failure to enact mental health parity. Let's work to ensure that those who need access to mental health care, get it.

Mr. TERRY. Mr. Speaker, today the House is considering H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. I strongly support the mental health community and believe that millions of Americans living with mental health illness and addiction need access to treatment. Screening and early treatment remains an important and cost-effective way of combating mental health illness and addiction.

Unfortunately, the bill before us today seeks to extend mental health treatment by stifling innovation, increasing health insurance cost to employers and employees and mandates that ALL diagnoses, such as 'jet lag' and 'caffeine intoxication' listed in the DSM–IV be covered.

A provision in H.R. 1424 also seeks to limit physician ownership in hospitals, regardless of whether those hospitals are in rural or small communities. Physician owned hospitals strive to eliminate preventable complications and errors in order to improve patient care. Specialty care hospitals are an integral part of our community in Nebraska. They provide quality care and help keep costs down. A February article in Forbes highlighted a University of Iowa study which found that tens of thousands of Medicare patients' complication rates for hip and knee surgeries were 40 percent lower at specialty hospitals than at other hospitals.

Mr. Speaker, unlike the Senate bill which requires that insurance companies consider all mental ailments listed in the Diagnostic and Statistical Manual of Mental Disorders, the legislation before us goes one step further by requiring groups which offer mental health benefits to cover all diagnoses under the DSM–IV, this includes disorders such as 'jet lag' and 'caffeine intoxication.' Furthermore, groups would be required to extend current mental health benefits regardless of religious or moral objections they may have to paying for the treatment of psycho-sexual disorders or dubious complaints of less serious problems.

Finally, the bill would increase health insurance costs. The CBO estimates that by 2012, H.R. 1424 would cost $3 billion annually, a cost which would be passed on to employers and employees.

I am concerned that the government mandate currently proposed by H.R. 1424, though well-intentioned, could actually reduce access to mental health care. Many health plans are already responding to customer demand by gradually implementing greater coverage of mental health treatments. Mandating that such coverage would be immediately equal with medical and surgical benefits could force some plans to drop mental health benefits altogether leaving Americans in need of coverage with none at all.

Mr. Speaker, I wanted to come to this floor and vote for a Mental Health Parity bill like the one I supported in the Energy and Commerce Committee last fall. Unfortunately, this is not the same legislation, and therefore I must reluctantly oppose it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act, introduced by my distinguished colleague from Rhode Island, Representative PATRICK J. KENNEDY, but ask for a closer at Section 6, and its effect on physician-owned general hospitals.

I have opposed H. Res. 1014, the rule which provided for consideration of H.R. 1424; however, I am in support of the bill itself.

This bill permanently reauthorizes and expands the Mental Health Parity Act of 1996 to provide for equity in the coverage of mental health and substance disorders as compared to medical and surgical disorders. This legislation ensures that group health plans do not charge higher co-payments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than for medical and surgical benefits.

Although this legislation does not mandate group health plans, if a plan does offer mental health coverage, then this legislation would require it to offer equity in its: (1) financial requirements applied to mental health and substance-related disorders, (2) equity in treatment limitations, (3) prohibit discrimination by diagnosis, and (4) equality in out-of-network coverage.

This legislation provides for greater transparency in medical management, and strict enforcement by the Internal Revenue Service, something we all want to see more of in the health care industry.

Over the past several decades, America's health care system has been a leader in innovation. This innovation has given patients unprecedented access to specialized care in all different fields of medicine. Whether it's in cancer centers, children's hospitals, or ambulatory surgical centers, patients now have the ability to receive quality care in a hospital of their choice.

Unfortunately, this bill stifles the very innovation and choice that has laid the groundwork to real transformation in our health care system. A provision in H.R. 1424 would severely restrict the ability and capacity of physician owned hospitals to provide quality healthcare to their patients. It does not matter if the hospital is rural, inner city, big or small this legislation will punish these hospitals, the doctors and the nurses that serve their community every day by restricting them from providing high quality care to their patients. Physician owned hospitals serve as an integral part in the future of patient care and should not be dismissed just because they have physician investment.

In Texas, we have inpatient rehabilitation hospitals, long-term acute care hospitals, general care hospitals, and community hospitals that are nationally recognized as the best in the industry and each and every one of them has physician investment. Patients across the great state of Texas have greatly benefited from the safety, quality, and innovation that physician owned hospitals bring.

In an era when hospital deaths from infections, medical errors, and other problems approach 100,000 a year, physician owned hospitals have placed a very large emphasis on eliminating preventable complications and errors in order to improve patient care.

Just this month in a Forbes article, a University of Iowa study found that tens of thousands of Medicare patients' complication rates for hip and knee surgeries were 40 percent lower at specialty hospitals than at other hospitals. These hospitals provide a needed service and they must be allowed to continue their good work now and in the future.

Before Senator Paul Wellstone's untimely death and that of his wife and daughter, I had the opportunity to meet with him and work with him on these very issues. His dedication to creating affordable healthcare for all Americans is what is at the root of this legislation. Having a provision that actually seeks to restrict physicians and hospitals seems to obliterate the bipartisanship and purpose of this bill.

We all support the goal of equal access to mental health benefits. However, we should not believe that it should be paid for by sacrificing facilities that bring quality, efficient and accessible healthcare to all patients.

I urge my colleagues to take a closer look at the effect this legislation will have on physician-owned hospitals. Despite my reservations regarding the disproportionate impact on physician-owned hospitals, ultimately patients benefit from this legislation and therefore I ask each of you to join me in supporting H.R. 1424.

Mr. CONYERS. Mr. Speaker, I rise to voice my strong support for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, which requires equity in the provision of mental health and substance-related disorder benefits under group health plans. This much needed legislation would finally provide for true mental health insurance parity, offering mental health and substance-abuse benefits on par with medical and surgical benefits, ending discrimination against patients seeking treatment for psychiatric disorders.

Mental illnesses have a devastating effect on our nation. According to a 2005 Harvard study, over 35 million Americans suffer from a moderate or serious mental disorder in any given year. Societal costs, such as loss of productivity and the burden on family caregivers, total $113 billion annually. As well, the President's New Freedom Commission on Mental Health reported in 2003 that mental illnesses constitute the leading cause of disability in the United States; the Commission noted that half of those who need mental health treatment in this country do not receive it.

The treatment of mental illness works. Unfortunately, only those who are able to access care can benefit from it. Most mental disorders are chronic, ongoing illnesses that require consistent and persistent treatment in order to achieve remission. It would seem unconscionable to limit the number of times a cancer patient sees their oncologist for treatment; those suffering from severe psychiatric illness should not be held to a lesser standard of care.

Despite disinformation put forth by some of my colleagues today, the concept of mental health insurance parity is not a new one. In fact, as members of Congress, we all enjoy the benefits of mental health parity that our constituents are deprived of. The Federal Employees Health Benefits (FEHB) Program has offered mental health and substance-abuse benefits on a par with general medical benefits since 2001. A convincing study of the FEHB program published by the New England Journal of Medicine in 2006 proves that the implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

Mr. Speaker, the inequity of coverage with regard to mental health and substance abuse treatment benefits is tantamount to discrimination against the mentally ill, and it reinforces the strategy of insurance companies to deny care rather than provide care. It is our duty to end this intolerable discrimination against the mentally ill, and pass H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007.

Mr. SHULER. Mr. Speaker, I rise in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. The passage of this bill is an important step for those suffering from mental health problems in this country.

I believe it should not be an uphill battle to get treatment for millions of Americans living with mental illness and addiction. Thanks to my colleagues Mr. KENNEDY and Mr. RAMSTAD we are moving towards achieving parity between mental and physical conditions.

While I support the underlying legislation, I oppose the closed rule under which it is being introduced, because it does not provide for an opportunity to address the revenue raisers included in the bill. I am particularly concerned with the offset used to pay for the legislation, specifically the Medicaid prescription drug rebate.

Increasing these rebate rates could have a chilling effect on pharmaceutical research and development for the next generation of treatments, including those that aid patients with mental health conditions that we are attempting to help today.

I urge the passage of this bill. However, as this bill advances to conference, I hope that the final product that returns to the House will not contain an increased Medicaid rebate or any other provision that will deter the innovation of new treatments for the diseases that affect American families.

Mr. ETHERIDGE. Mr. Speaker, I rise today in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. As a cosponsor of this important legislation, I applaud your leadership in bringing this bill to the floor and addressing the issue of mental health panty.

According to the National Institute of Mental Health (NIMH), approximately 26.2 percent of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder. Unfortunately, the U.S. Surgeon General reports that only one in three of these people receive treatment for their disabilities. A significant reason that people fail to seek medical help for debilitating mental health issues is the lack of insurance.

The Paul Wellstone Mental Health and Addiction Equity Act would help address this problem. By requiring health plans to consider mental health issues on an equal basis with other health problems, this bill ensures that those in need can get the treatment that is medically necessary. We must expand access to mental health to ensure a strong and productive America that provides for its most vulnerable citizens.

Untreated and mistreated mental illness costs the United States $105 billion in lost productivity, a figure that has been increasing every year. According to a study funded by NIMH, treating mental health in the workplace significantly improves employee health and productivity, likely leading to overall lower costs for the employer. Mental health also has a high cost to society—for example, 20 percent of youths in juvenile justice facilities have a serious emotional disturbance and most have a diagnosable mental disorder. This bill will improve our economy and ensure those in need get the help they need before their illness turns into something worse.

My home state of North Carolina was one of the first states to adopt a mental health parity law back in 1991, and last year the State Legislature expanded and strengthened its mental health parity provisions. I support the efforts of North Carolina's mental health professionals in bringing this issue to the forefront of our State's agenda.

Mr. Speaker, while I strongly support this bill, I disagree with part of the bill's funding mechanism. We must be fiscally responsible, but we should not allow cost offsets to undermine the basic goals of this bill. I am concerned that the large increase in the Medicaid prescription drug rebate will reduce the ability of patients, including those with mental health conditions, to get the prescription medicines they need.

H.R. 1424 calls for a 33 percent increase in the rebate that brand pharmaceutical companies pay to the Medicaid program. Innovator drug companies already provide deep discounts to Federal and State Governments for

the prescription drugs covered by the Medicaid program. I am concerned that a huge increase in costs will have a chilling effect on pharmaceutical research and development for the next generation of treatments, including those that aid the very patients with mental health conditions that we are attempting to help today. Mr. Speaker, I hope that you and the House conferees will work to address this issue in conference negotiations with the Senate.

After careful consideration, I urge my colleagues to join me in voting for H.R. 1424.

Mr. LANGEVIN. Mr. Speaker, I rise in strong support of the Paul Wellstone Mental Health and Addiction Equity Act of 2007, which I am proud to cosponsor. I know many people have worked hard to bring this important measure to the floor, including my friend from Minnesota, the co-chair of the Bipartisan Disabilities Caucus, Mr. RAMSTAD. Most of all, I would like to recognize the commitment and perseverance of my good friend and colleague from Rhode Island, PATRICK KENNEDY. PATRICK has been my good friend for many years, and I have watched him harness his passion and his knowledge to address the challenges faced by those with mental illness. He has raised awareness about a topic that had previously been considered taboo by the American people, using his own personal experiences to humanize the issue of mental health. I know that the people of Rhode Island admire his leadership, and I thank him for his tireless efforts.

Mental illnesses and substance abuse problems are at epidemic levels in this country. According to recent estimates, more than 35 million Americans experience the disabling symptoms of mental illness. Depression alone costs employers over $35 billion dollars a year in lost productivity, and that figure does not even factor in the multitude of other behavioral and psychological disorders that challenge our society on a daily basis. Substance abuse also directly affects an estimated 25 million Americans. An additional 40 million are indirectly affected once family members of abusers and the injured victims of intoxicated drivers are considered. Put simply, the social and monetary costs of these problems are astounding.

This bipartisan legislation makes tremendous strides in ending the inherent discrimination in our insurance system against patients seeking treatment for these illnesses. It permanently reauthorizes and expands the Mental Health Parity Act of 1996 to provide for equity in the coverage of mental health and substance-related disorders. It does not achieve equity by mandating that group health plans provide mental health coverage. However, if a plan chooses to offer coverage—as it rightfully should—then the coverage it offers must be no more restrictive in the financial requirements or treatment limits that are provided for medical or surgical disorders. This will mean equity in deductibles and co-pays, as well as in the frequency and number of visits. It will also establish parity for out-of-network coverage. In short, it will vastly expand coverage and access for those seeking treatment for their mental health.

Mental health parity is already available to members of Congress and over 8 million Federal employees under the Federal Employee Health Benefits Program, FEHBP, at minimal additional cost to the program. It is time that we extend this benefit to all Americans, and this legislation takes us considerably closer to that goal. I strongly urge my colleagues to vote in favor of this bill.

Mr. MCDERMOTT. Mr. Speaker, today is an historic day. Along with others, I have labored for a very long time to produce a comprehensive mental health parity bill. Without a doubt, our actions today will benefit real people in real ways. Many times we come to the floor to debate and vote on legislation that many Americans may wonder what is the relevance or the purpose? No one who has suffered a mental illness or has watched a family member suffer a mental illness will ask what is the relevance?

As a doctor and psychiatrist, I want to emphasize to my colleagues that this bill will make a genuine difference in the lives of the American people we serve. I know the suffering of mental illness. Not only do many patients still face the stigma of mental illness, but they also face discrimination in coverage.

Most Americans would be outraged if they heard that health plans charged higher copayments for cancer treatments or limited hospitals stays for those with heart diseases or denied care for diabetes. We would all be outraged. But, that is what we allow for mental illness.

We have heard a great deal about the costs of requiring mental health parity. What we hear very little about is the cost of not providing mental health parity. Many untreated mental illnesses can metastasize into serious physical and costly illnesses. Untreated depressions can result in heart disease. An untreated eating disorder can result in kidney failure. Yet, had we treated the mental illness we could have saved millions of dollars in costly care.

The issue of increasing costs of insurance is simply and categorically false. We know from the FEHBP experience that mental health parity has not resulted in significant costs. In fact, CBO has reported that H.R. 1424 would increase premiums by just two tenths of one percent. I would argue the longer term savings would offset any increase in premiums and that we will see a savings.

Access to mental health is simply access to quality primary care. It's key to preventing disease and improving outcomes. It simply makes no sense to treat the brain differently than the kidney or lungs or heart.

We have also heard a great deal about the use of the DSM–IV and scope of coverage. The use of DSM–IV is a tool for diagnosing mental illness and ensures that doctors, not insurance companies, define a mental illness. Some of my colleagues have argued that the use of DSM–IV will mean that plans must cover jet lag. These are not DSM diagnoses and refer to V Codes and not developed for the DSM.

My colleagues also argue that the use of the DSM–IV will prohibit plans from medical management. Again, my colleagues are wrong. As a practitioner, let me assure you that diagnosing and treating illness are very different things. Treatments can and will still be subject to medical necessity, like any other illness.

I think it is important for me to correct the record. Many of the speakers who addressed the House today are not health care professionals and have little understanding of mental illness. Yet, they claim to be experts on diagnosing and treating mental illness.

Finally, let me say a few words about the physician ownership offset. Just a couple of weeks ago, the administration sent to the Congress the Medicare 45 percent trigger recommendations. We have heard over and over again that Medicare spending is not sustainable and we need radical reforms. Yet, when we offer a small reform measure that will save more than $2 billion over 10 years, and protect patients from unnecessary care, some Members come to the floor to oppose. In fact, they argue that this physician ownership issue reduces choice or access. Who chooses to spend $2 billion more?

I understand that there may be some clinics that are providing quality care and we need to work to ensure that Medicare beneficiaries are not denied access. But, let's remember what we are doing. This is about closing a loophole to limit physician ownership of medical facilities to reduce over utilization and protect full service community hospitals. Many of these physician owned facilities do not staff an emergency department or an ICU. This is about protecting the integrity of the Medicare program. This is about controlling Medicare spending.

I strongly support H.R. 1424. Let's end this inhumane practice of discriminating against those with a mental illness. Let's make sure that when families pay premiums for health insurance coverage that they have the right to medically necessary coverage.

Mr. KIND. Mr. Speaker, I rise today in strong support of long overdue legislation that would equalize care for the millions of Americans suffering from mental health and substance-related disorders. More than 10 years after passing the Mental Health Parity Act, Congress now has the chance to finish the job it began and ensure that no Americans face discrimination in insurance coverage of mental health care.

Patients throughout the country struggle with the enormous financial costs of mental health and substance abuse treatments not covered by insurance. Many go without treatment, creating a burden on families, communities, and even our economy. Over 1.3 billion work days are lost annually due to mental disorders, more than stroke, heart attack, and cancer combined. In addition, employers face $135 billion in lost productivity each year due to untreated alcoholism and $31 billion due to untreated depression.

Enacting H.R. 1424 is important not only as a way to remove barriers to mental health and substance abuse care, however, but also as a way to remove the stigma long associated with these disorders. Equalizing care would send a strong message that the 57 million Americans suffering from mental health disorders and 26 million from chemical addiction should be treated no differently than individuals suffering from other medical conditions. I applaud the leadership and work of Representatives KENNEDY and RAMSTAD for their tireless efforts to bring this important legislation forward, and I am proud to give them my strong support.

In moving forward, it is my hope that the House and Senate can work together to find common ground so that mental health parity can be enacted. as part of this process, I would encourage negotiators to review the offsets used to pay for H.R. 1424, particularly the increase in the base Medicaid drug rebate level. I encourage Congress to consider the

effect this increase would have on small businesses that provide drugs and biologics to the Medicaid program, as well as possible disincentives this increase could create for companies to innovate and develop important new medicines. Although I am not opposed to raising the base rebate amount on principle, I am concerned that it may not be a prudent step to take without a thoughtful and complete review of its possible impacts.

Ms. BALDWIN. Mr. Speaker, I rise in strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act.

All Americans deserve access to affordable, comprehensive health care—to meet both their physical and mental needs. I believe that Americans should be provided comprehensive coverage for mental health services. Mental illness and substance abuse are real and treatable health problems—just like hypertension, cancer and heart disease; yet millions of hard-working men and women still find that their health plans place strict limits on coverage for mental health benefits.

I am proud to be an original cosponsor of H.R. 1424. This bill will finally provide for equity in coverage of mental health and substance-related disorders.

We know all too well the inequities that currently exist for those seeking mental health care and substance-related care. They are subjected to higher co-payments, higher deductibles, and more restrictive treatment limits.

I have heard hundreds of heart-wrenching stories from my constituents in Wisconsin about the effects that these inequities have had on their families.

One woman's story was especially poignant about the inequities of the current system. In the same year, both her husband and her daughter required major medical care because of life-threatening conditions. One had a disease of the kidneys, and one suffered from severe clinical depression. Both patients required emergency visits and extended treatment. Both patients were compliant and followed their doctor's treatment instructions. Both patients were covered under the same family policy.

But the insurance paid for twice as much of the costs associated with the kidney disease than they did for the severe depression, because depression is a mental illness.

And while her husband underwent multiple treatments for his kidney disease, her daughter was told after a few psychiatric visits that her insurance would not pay anything toward further visits because she had used up her allotted number of visits for the year.

These higher patient costs and treatment limits are unconscionable. I am delighted that H.R. 1424 will require equity in financial commitments and equity in treatment limits for mental health and substance-related disorders as compared to medical and surgical benefits. In addition, it will prohibit discrimination by diagnosis and provide Americans with the same mental health coverage that Members of Congress have.

Mr. Speaker, I urge my colleagues to join me in voting in favor of H.R. 1424.

Mr. BUTTERFIELD. Mr. Speaker, I rise today in strong support of the H.R. 1424—Paul Wellstone Mental Health and Addiction Equity Act of 2007. This legislation is a great step in ensuring that group health plans are discouraged from charging higher co-payments, coinsurance, deductibles, and imposing the maximum out-of-pocket limits on mental health and addiction care than those imposed for medical and surgical benefits.

Although I fully support the intent of this measure, Mr. Speaker, I have slight reservation over one of the offsets used to pay for the legislation, specifically the large increase in the Medical prescription drug rebate.

Innovative drug companies already provide deep discounts to Federal and state governments for prescription drugs covered by the Medicaid program. H.R. 1424 calls for a 33 percent increase in the rebate that brand pharmaceutical companies pay to the Medicaid program at a time when many drug companies are facing big financial challenges.

As a member of the North Carolina delegation, I realize the economic impact that this innovative industry has on my State, employing over 25,000 North Carolinians with many coming from my congressional district. I also understand the threat that this rebate poses to research, development, and access to drugs for the Medicaid beneficiaries of my poverty stricken district. We need these companies to continue investing in the United States, creating good jobs, and developing the new drugs our patients need.

Mr. Speaker, it is my hope that the House will come together and support this progressive piece of legislation. I am pleased that we did not give up on this bill and have moved forward despite the President's veto of the Children's Health and Medicare Protection Act of 2007. Further, I would also like to encourage my colleagues who will be engaged in the conference negotiations to bring to us a final product that will not deter innovation of new treatments for the diseases and ailments that affect American families.

Mr. SESSIONS. Mr. Speaker, today on the floor of the House of Representatives we are considering the issue of mental health parity. Unfortunately, some of my colleagues have clouded this important issue with extensive and over-burdensome regulations. As a supporter of mental health parity it is regrettable that I can not support the bill at hand. With over 50 million adults suffering from mental disorders it is necessary that there is access to mental health services. The Senate has passed legislation on parity that will allow access to these needed services, and I applaud and support their efforts.

As a long time supporter of the Genetic Information Non-Discrimination Act, it is disappointing that this legislation was coupled in with the over regulated mental health parity bill. Congress has taken great strides over the last few years towards adequately protecting an individual's genetic information an encouraging lifesaving genetic testing. Attaching this legislation to the flawed parity bill puts those efforts to shame. Congress should take up the Genetic Information Nondiscrimination Act on its own and allow those, like myself, to vote in favor of the bill.

Mrs. BEAN. Mr. Speaker, I rise in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. The passage of this bill is an important step for those suffering from mental health and substance-related disorders in this country.

I believe it should not be an uphill battle for the millions of Americans living with mental illness and addiction to receive quality care. Thanks to my colleagues, Mr. KENNEDY and Mr. RAMSTAD, we are taking strides to achieve parity between mental and medical conditions.

While I support achieving mental health parity, I am concerned about using the Medicaid prescription drug rebate as an offset to pay for this legislation.

Innovator drug companies already pay significant rebates to Federal and state governments for their prescription drugs to be covered by the Medicaid program. As a result of this "best price" policy, Medicaid programs already obtain drugs at a below-market price. I am concerned that further increasing this rebate will have a chilling effect on pharmaceutical research and development for the next generation of treatments, including those that aid the patients with mental health conditions we are helping today.

As the economy weakens and our manufacturers are courted with large subsidies to move their operations and jobs overseas, we must not stifle innovation. We need our pharmaceutical companies to continue investing in the United States, creating good jobs, and inventing new drugs our patients need.

I urge the passage of H.R. 1424. However, as this bill advances to conference, I hope the final product that returns to the House will not contain an increased Medicaid rebate, or any other provision that will deter the innovation of new treatments for the diseases that affect American families.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, as a psychiatric nurse with 15 years of hands-on patient care experience, I strongly support mental health parity. All health insurers should provide coverage for mental and behavioral care.

An overwhelming body of evidence links mental- and emotional well-being to physical well-being. Simply put, the two go hand-in-hand.

For too long, too many health insurance companies have cut corners, when it comes to providing mental health benefits. Left to the "free market system," many insurers have opted not to cover mental health care, claiming that it is not medically necessary, or simply ignoring the issue and forcing patients to absorb the costs.

For too long, patients have suffered unfair expenses or delayed getting care, and the economic impact to our society has been large. Suicides, missed work due to depression, and other mental health issues have been the result of private industry's refusal to offer mental health benefits.

It is time that we put this harmful practice to a stop. I want to commend Representatives PATRICK KENNEDY, JIM RAMSTAD, and Senators TED KENNEDY and PETE DOMENICI for their tireless work to develop this legislation.

While I strongly support mental health parity, I believe that the Senate bill has been better tested by the stakeholder and business communities. The House version contains a provision, intended to help pay for the mental health benefit, that would result in reduced spending for physician-owned hospitals.

Baylor cardiovascular hospital, in my district in Dallas, would be affected by the provision. In order to collect future Medicaid reimbursements, the hospital would need to reduce its percentage of physician ownership; and growth of the hospital could be severely restricted.

It is my belief that Dallas residents are best served with as many options of affordable

health care as possible—including mental health care. I hope that the House and Senate can resolve differences in the final legislation that will not harm local hospitals, yet pay for the benefits without increasing the Federal deficit.

For me, the bottom line is this: mental health parity should have existed from the onset of our modern health insurance system. Mental wellness is just as important as physical wellness. The two are the foundation for a life of wholeness and satisfaction.

Again, I thank my colleagues, stakeholder groups, and members of the Other Body for their hard work on such a critical issue.

Mr. TANNER. Mr. Speaker, I rise today to express my concern with one of the proposals being used to fund this legislation. I agree that improving coverage of mental health services is a laudable goal, and long over due, I might add. However, the proposal to help fund this increased coverage through increasing the Medicaid drug rebate is troubling to me. Drug companies already provide deep discounts to Federal and State governments for the prescription drugs covered by the Medicaid program. This legislation calls for a 33 percent increase in that rebate. I hope that a substantial increase in the rebate will not have a chilling effect on research and development for the next generation of treatments for those very patients with mental health conditions we are trying to help today.

As everyone knows, I am a strong supporter of pay go provisions. So I want to commend our leadership for their efforts to continue to address these funding issues. The other funding provision being used for the improved coverage in this bill is designed to ensure that any potential conflict of interest created by physician ownership interests in specialty hospitals is limited. I think this provision goes a long way toward creating a more equitable situation for all hospitals.

I plan to support final passage of this legislation. However, I hope that we can work together as this process goes forward to negotiate a conference agreement that offers a more balanced approach.

Mr. DINGELL. Mr. Speaker, today we are voting on the passage of H.R. 1424, the ''Paul Wellstone Mental Health and Addiction Equity Act of 2007'', which will permanently reauthorize and improve the Mental Health Parity Act of 1996. I commend my distinguished colleagues, Representatives KENNEDY and RAMSTAD, for their efforts in crafting this important piece of legislation.

H.R. 1424 will create true parity of coverage for mental health and substance abuse disorders. It will ensure that healthcare plans that provide mental health coverage do not charge higher co-payments, coinsurance, or deductibles for mental health or substance abuse care. It will also ensure that care for mental health and addiction disorders is no more restrictive than medical or surgical care.

Mental illness and addiction disorders have long been recognized by the healthcare community as actual and legitimate health afflictions which may have a significant affect on an individual's life and well-being. It has long been accepted that these afflictions deserve treatment by professionally trained healthcare providers.

As I think of all of the different diseases and afflictions recognized by our scientific and healthcare communities, I struggle to find a reason why someone who has healthcare coverage should confront discriminatory barriers to treatment simply because of the nature of the disease. Mental health and addiction disorders can be just as painful and debilitating as medical and surgical disorders. The strains of these illnesses affect individuals, families, and society as a whole.

I urge my colleagues to vote to pass H.R. 1424 to achieve comprehensive mental health and substance abuse parity.

Mrs. JONES of Ohio. Mr. Speaker, today I rise in support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007. I am honored to support one of the many noble causes of the late Senator Paul Wellstone and strongly believe that this bill will address and improve our Nation's need for enhanced mental health services.

The plight of families suffering from mental illness is immense due to an absence of adequate social services and the unwarranted stigma surrounding mental health issues. Due to the unwarranted social stigma and a systemic failure to ensure health care coverage, over two-thirds of the people who suffer from mental illness go untreated according to the Department of Health and Human Services. Within minority communities, even greater needs exist for mental health services.

According to the National Institute on Mental Health, 20 percent of our children and 26.2 percent of American adults suffer from a diagnosable mental disorder in a given year. As the leading cause of disability in the U.S., many people suffer from more than one mental disorder at a given time. Thus, the need for mental health services is immense, and we cannot allow discriminatory practices by insurance companies to be an impediment to accessing available services.

Last year, I introduced H. Con. Res. 86 to express the sense of Congress that an appropriate month should be recognized as Bebe Moore Campbell National Minority Mental Health Awareness Month. Bebe Moore Campbell was a premier journalist who, before her untimely death, authored a children's book titled, Sometimes My Mommy Gets Angry, winner of the National Alliance for the Mentally Ill Outstanding Literature Award. Through this story of how a little girl copes with being reared by her mentally ill mother, Moore Campbell was able to raise public awareness of mental health issues and heighten the consciousness of this topic within minority communities.

In conclusion, I would like to affirm my support for H.R. 1424. This legislation is necessary to assist families who are struggling through the effects of mental illness and will contribute greatly to our Nation's overall wellness.

Mr. MORAN of Virginia. Mr. Speaker, I rise today in strong support of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. I want to congratulate Congressmen KENNEDY and RAMSTAD for their excellent work on this bill. Their effort to secure parity for all Americans suffering from mental heath conditions has truly been an historic one, and I am proud to stand here today and support the House's comprehensive mental health parity bill.

Mental health conditions are the leading cause of disability for Americans aged 15–44, and are implicated in 90 percent of the more than 30,000 suicides that occur here annually. Productivity loss due to depression costs employers an additional $31 billion per year before disability claims are even taken into account. Every day, patients suffering from these debilitating conditions are denied treatment by insurers who do not provide mental health coverage—patients who could be treated safely and effectively thanks to new advances in medicine.

Mental illness is, according to nearly all medical experts, a biologically-based illness just like getting cancer, or diabetes, or the flu. But in addition to the horrendous costs that untreated and unchecked mental illness imposes on patients and society as a whole, failure to provide parity in coverage for mental illness stigmatizes patients suffering from mental health conditions and decreases the likelihood that they will seek treatment that could aid their suffering and enable them to be more productive members of society. This unjust stigmatization has no biological or medical basis, and yet it threatens promising American lives every day. We do not blame cancer patients for having cancer—why should we treat patients suffering from mental health conditions any differently?

H.R. 1424 is a comprehensive mental health parity bill that will ensure access to vitally needed treatment for countless Americans currently suffering from mental health conditions. Again, I applaud my good friends on their efforts on this bill, and I am proud to support this historic legislation here today.

Mr. PALLONE. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired. Pursuant to House Resolution 1014, the previous question is ordered.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. HOEKSTRA

Mr. HOEKSTRA. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. HOEKSTRA. Yes, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

Mr. PALLONE. Mr. Speaker, I reserve a point of order.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Hoekstra of Michigan moves to recommit the bill, H.R. 1424, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the text of the bill H.R. 3773 as passed by the Senate on February 12, 2008.

The SPEAKER pro tempore. Does the gentleman from New Jersey continue to reserve his point of order?

Mr. PALLONE. Yes, I continue to reserve my point of order.

The SPEAKER pro tempore. The gentleman from Michigan is recognized for 5 minutes to speak in support of his motion.

Mr. HOEKSTRA. Mr. Speaker, this bill is intended to ensure the mental health of Americans; yet, no American's health can be fully secured if they are under attack by a terrorist or facing the potential threat of terrorist attack.

It has now been 18 days since the Protect America Act expired, taking with it the full array of enhanced tools for the intelligence community to aggressively investigate potential attacks and detect and prevent potential terrorist attacks. This motion to recommit would ensure the health of Americans by inserting the text of the Senate bill to modernize FISA.

Eighteen days is long enough; yet, the leadership of the House still has done nothing to appoint conferees on the Senate bill to modernize FISA.

The SPEAKER pro tempore. The gentleman will suspend.

Mr. PALLONE. Mr. Speaker, I insist on my point of order. The gentleman is not confining his remarks to the point of order.

The SPEAKER pro tempore. The point of order was reserved and the gentleman from Michigan was recognized on his motion to recommit.

Mr. HOEKSTRA. Thank you, Mr. Speaker. May I continue?

The SPEAKER pro tempore. The gentleman from Michigan may continue.

Mr. HOEKSTRA. As I said, as we deal with this bill, 18 days is a long time, yet the leadership of this House still has done nothing to appoint conferees on the Senate bill to modernize the Foreign Intelligence Surveillance Act, which passed the Senate with overwhelming bipartisan support and is supported by a majority of the House. The Democratic leadership continues to block this bill, even though a number of responsible Democrats support it and the bill will pass if brought to the floor.

It was 18 days ago, it was 3 weeks ago that it was brought to the floor to have a 3-week extension, on top of a 2-week extension, on top of a 6-month extension. It is time to move this bill forward and to again give our intelligence community the tools that they need, the enhanced tools that many recognized after 9/11 that the intelligence community needed to keep America safe. It is time to bring up the Senate-passed FISA bill.

In the 18 days since the expiration of the Protect America Act, we have already seen multiple examples where our country's ability to follow up on potential threats has been significantly impaired.

In Tampa, the Transportation Security Administration stopped a man trying to board a plane with a box cutter in his backpack. Officers also found books in the backpack titled "Muhammad in the Bible," "The Prophet's Prayer," and "The Noble Qur'an." There may be instances in that situation where there may be intelligence clues that we would want to follow up. We want to know whether there are any connections to foreign terrorists and whether at that very moment there may be other people in other airports trying to board planes with box cutters.

We don't want our intelligence officials to have to wait for lawyers to fill out voluminous paperwork in order to obtain permission from a Federal judge to follow up on those leads. Precious time could have been lost while an attack was in progress.

Last Friday, authorities found toxic ricin, or perhaps toxic ricin, in a hotel room in Las Vegas. Absent any evidence in the hotel room to prove probable cause that the ricin was tied to international terrorists, it may have been impossible for the intelligence community to follow up on any evidence that may have pointed to a suspected tie with foreign terrorists.

These are the things that happen in the United States. When you take a look at other things that are happening around the world, our troops in harm's way in both Iraq and Afghanistan, our brave men and women who are serving in the embassies in the Foreign Service around the world today, it is important that our intelligence community be given the tools and the techniques to keep Americans, our servicemen, our embassies, and our foreign personnel safe.

It has now been 18 days. The majority promised us that they could deal with this issue, first they said in 6 months, then they said in 2 weeks, then they said in 3 weeks. It has clearly been much more time than that, and every day that we delay, we lose a little bit of our capability to track the threats that face this country.

The chairman of the Senate Intelligence Committee has said the same thing. The Director of National Intelligence has said the same thing. So now for 18 days our capabilities have slowly been eroding, but each day piles on to the loss that we had from the day before.

There are real threats out there. There are real threats to Americans, to our troops, and to other individuals serving overseas. It is time to make sure that our intelligence community has all of the tools that it needs to keep America safe. We need to join with the Senate. We need to join with the 68 in the other body who overwhelmingly passed a bipartisan FISA modernization bill that gives the intelligence community the tools that they need to keep America safe.

I call on my colleagues and the leadership on the other side of the aisle to support this motion to recommit, to send a clear signal, and then to move forward on an overall bill. Because if this passes today, what it will do is send a clear signal.

POINT OF ORDER

Mr. PALLONE. Mr. Speaker, I insist on my point of order.

I raise a point of order that the motion to recommit contains nongermane instructions in violation of clause 7 of Rule XVI. The instructions in the motion to recommit address an unrelated matter within the jurisdiction of a committee not represented in the underlying bill.

The SPEAKER pro tempore. Does any other Member wish to be heard on the point of order?

PARLIAMENTARY INQUIRIES

Mr. HOEKSTRA. Yes, I do.

Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. HOEKSTRA. Under the rule, the text of H.R. 493, as passed by the House, is added at the end of this bill. H.R. 493 deals with genetic information discrimination. The title of the bill is "genetic information" and not mental health.

Mr. Speaker, how is it that a genetic information discrimination bill can be added to a mental health bill but the FISA bill to protect us from terrorist attack cannot?

The SPEAKER pro tempore. That additional text will be added by operation of House Resolution 1014 upon passage of the bill.

Mr. HOEKSTRA. Mr. Speaker, further parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. HOEKSTRA. If I understand the Speaker and if you have just answered my question correctly, the majority has the tools at its disposal to include the FISA bill in any legislation that passes the House but is refusing to do so?

The SPEAKER pro tempore. That is not an appropriate parliamentary inquiry.

Does any Member wish to speak further on the point of order? If not, the Chair is prepared to rule.

The Chair will rely on the precedents of February 26 and February 27, 2008. The instructions in the motion to recommit address foreign intelligence surveillance, a matter unrelated to issues of health and mental health and within the jurisdiction of committees not represented in the underlying bill. The instructions are therefore not germane and the point of order is sustained. The motion is not in order.

Mr. HOEKSTRA. Mr. Speaker, I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

MOTION TO TABLE OFFERED BY MR. PALLONE

Mr. PALLONE. Mr. Speaker, I move to table the appeal.

The SPEAKER pro tempore. The question is on the motion to table.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. HOEKSTRA. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 223, nays 186, answered ''present'' 1, not voting 18, as follows:

[Roll No. 99]

YEAS—223

Abercrombie
Ackerman
Allen
Altmire
Andrews
Arcuri
Baca
Baird
Baldwin
Barrow
Bean
Becerra
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boren
Boswell
Boucher
Boyd (FL)
Boyda (KS)
Brady (PA)
Braley (IA)
Brown, Corrine
Butterfield
Capps
Capuano
Cardoza
Carnahan
Carney
Castor
Chandler
Clarke
Clay
Cleaver
Clyburn
Cohen
Cooper
Costa
Costello
Courtney
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (IL)
Davis, Lincoln
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Donnelly
Doyle
Edwards
Ellison
Ellsworth
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Frank (MA)
Giffords
Gilchrest
Gillibrand
Gordon
Green, Al
Green, Gene
Grijalva
Gutierrez
Hall (NY)
Hare
Harman
Hastings (FL)
Herseth Sandlin
Higgins
Hill
Hinchey
Hinojosa
Hirono
Hodes
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (GA)
Jones (OH)
Kagen
Kanjorski
Kaptur
Kennedy
Kildee
Kilpatrick
Kind
Klein (FL)
Kucinich
LaHood
Langevin
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren, Zoe
Lowey
Lynch
Mahoney (FL)
Maloney (NY)
Markey
Matheson
Matsui
McCarthy (NY)
McCollum (MN)
McDermott
McGovern
McIntyre
McNerney
McNulty
Meek (FL)
Meeks (NY)
Melancon
Michaud
Miller (NC)
Miller, George
Mitchell
Mollohan
Moore (KS)
Moore (WI)
Moran (VA)
Murphy (CT)
Murphy, Patrick
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Pallone
Pascrell
Pastor
Paul
Payne
Perlmutter
Peterson (MN)
Pomeroy
Price (NC)
Rahall
Ramstad
Reyes
Richardson
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Ryan (OH)
Salazar
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schwartz
Scott (GA)
Scott (VA)
Serrano
Sestak
Shea-Porter
Sherman
Shuler
Sires
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Space
Spratt
Stark
Stupak
Sutton
Tanner
Tauscher
Taylor
Thompson (CA)
Thompson (MS)
Tierney
Towns
Tsongas
Udall (CO)
Udall (NM)
Van Hollen
Velázquez
Visclosky
Walz (MN)
Wasserman Schultz
Waters
Watson
Watt
Waxman
Weiner
Welch (VT)
Wexler
Wilson (OH)
Wu
Yarmuth

NAYS—186

Aderholt
Akin
Alexander
Bachmann
Bachus
Barrett (SC)
Bartlett (MD)
Barton (TX)
Biggert
Bilbray
Bilirakis
Bishop (UT)
Blackburn
Bonner
Bono Mack
Boozman
Boustany
Brady (TX)
Broun (GA)
Brown (SC)
Buchanan
Burgess
Burton (IN)
Buyer
Calvert
Camp (MI)
Campbell (CA)
Cannon
Cantor
Capito
Carter
Castle
Chabot
Coble
Cole (OK)
Conaway
Crenshaw
Cubin
Culberson
Davis (KY)
Davis, David
Davis, Tom
Deal (GA)
Dent
Diaz-Balart, M.
Doolittle
Drake
Dreier
Duncan
Ehlers
Emerson
English (PA)
Everett
Fallin
Feeney
Ferguson
Flake
Forbes
Fortenberry
Fossella
Foxx
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gingrey
Gohmert
Goode
Goodlatte
Granger
Graves
Hall (TX)
Hastings (WA)
Hayes
Heller
Hensarling
Herger
Hobson
Hoekstra
Hulshof
Hunter
Inglis (SC)
Issa
Johnson, Sam
Jones (NC)
Jordan
King (IA)
King (NY)
Kingston
Kirk
Kline (MN)
Knollenberg
Kuhl (NY)
Lamborn
Lampson
Latham
LaTourette
Latta
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas
Lungren, Daniel E.
Mack
Manzullo
Marchant
Marshall
McCarthy (CA)
McCaul (TX)
McCotter
McCrery
McHenry
McHugh
McKeon
McMorris Rodgers
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy, Tim
Musgrave
Myrick
Neugebauer
Nunes
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Porter
Price (GA)
Pryce (OH)
Putnam
Radanovich
Regula
Rehberg
Reichert
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Roskam
Royce
Ryan (WI)
Sali
Schmidt
Sensenbrenner
Sessions
Shadegg
Shays
Shimkus
Shuster
Simpson
Smith (NE)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Tancredo
Terry
Thornberry
Tiahrt
Tiberi
Turner
Upton
Walberg
Walden (OR)
Walsh (NY)
Wamp
Weldon (FL)
Weller
Westmoreland
Whitfield (KY)
Wilson (NM)
Wilson (SC)
Wittman (VA)
Wolf
Young (AK)
Young (FL)

ANSWERED ''PRESENT''—1

Johnson (IL)

NOT VOTING—18

Blunt
Boehner
Brown-Waite, Ginny
Conyers
Cuellar
DeFazio
Diaz-Balart, L.
Gerlach
Gonzalez
Johnson, E. B.
Keller
Poe
Rangel
Renzi
Rush
Saxton
Woolsey
Wynn

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised 2 minutes remain in the vote.

□ 1922

Messrs. JORDAN of Ohio, HALL of Texas, MCCOTTER, and PLATTS changed their vote from ''yea'' to ''nay.''

Mr. LYNCH changed his vote from ''nay'' to ''yea.''

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

## MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has agreed to without amendment a concurrent resolution of the House of the following title:

H. Con. Res. 289. Concurrent resolution honoring and praising the National Association for the Advancement of Colored People on the occasion of its 99th anniversary.

The message also announced that pursuant to the provisions of S. Con. Res. 67 (110th Congress), the Chair, on behalf of the Vice President, appoints the following Senators to the Joint Congressional Committee on Inaugural Ceremonies:

The Senator from Nevada (Mr. REID).

The Senator from California (Mrs. FEINSTEIN).

The Senator from Utah (Mr. BENNETT).

## PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007—Continued

MOTION TO RECOMMIT OFFERED BY MR. KLINE OF MINNESOTA

Mr. KLINE of Minnesota. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. KLINE of Minnesota. In its current form I am.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Kline of Minnesota moves to recommit the bill, H.R. 1424, to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with the following amendment:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Mental Health Parity Act of 2008''.

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


Sec. 1. Short title; table of contents.
Sec. 2. Mental health parity.
Sec. 3. Effective date.
Sec. 4. Federal administrative responsibilities.
Sec. 5. Asset verification through access to information held by financial institutions.


**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)