

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 1424
OFFERED BY MR. GEORGE MILLER OF
CALIFORNIA**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

5 (b) TABLE OF CONTENTS.—The table of contents of
6 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.

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

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

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

1 “(3) TREATMENT LIMITS.—

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

11 “(B) TREATMENT LIMIT.—If the plan or
12 coverage includes a treatment limit on substan-
13 tially all medical and surgical benefits in any
14 category of items or services, the plan or cov-
15 erage may not impose such a treatment limit on
16 mental health or substance-related disorder
17 benefits for items and services within such cat-
18 egory that is more restrictive than the predomi-
19 nant treatment limit that is applicable to med-
20 ical and surgical benefits for items and services
21 within such category.

22 “(C) CATEGORIES OF ITEMS AND SERV-
23 ICES FOR APPLICATION OF TREATMENT LIMITS
24 AND BENEFICIARY FINANCIAL REQUIRE-
25 MENTS.—For purposes of this paragraph and

1 paragraph (4), there shall be the following five
2 categories of items and services for benefits,
3 whether medical and surgical benefits or mental
4 health and substance-related disorder benefits,
5 and all medical and surgical benefits and all
6 mental health and substance related benefits
7 shall be classified into one of the following cat-
8 egories:

9 “(i) INPATIENT, IN-NETWORK.—Items
10 and services not described in clause (v)
11 furnished on an inpatient basis and within
12 a network of providers established or rec-
13 ognized under such plan or coverage.

14 “(ii) INPATIENT, OUT-OF-NETWORK.—
15 Items and services not described in clause
16 (v) furnished on an inpatient basis and
17 outside any network of providers estab-
18 lished or recognized under such plan or
19 coverage.

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

1 “(iv) OUTPATIENT, OUT-OF-NET-
2 WORK.—Items and services not described
3 in clause (v) furnished on an outpatient
4 basis and outside any network of providers
5 established or recognized under such plan
6 or coverage.

7 “(v) EMERGENCY CARE.—Items and
8 services, whether furnished on an inpatient
9 or outpatient basis or within or outside
10 any network of providers, required for the
11 treatment of an emergency medical condi-
12 tion (including an emergency condition re-
13 lating to mental health and substance-re-
14 lated disorders).

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

22 “(E) PREDOMINANCE.—For purposes of
23 this subsection, a treatment limit or financial
24 requirement with respect to a category of items
25 and services is considered to be predominant if

1 it is the most common or frequent of such type
2 of limit or requirement with respect to such cat-
3 egory of items and services.

4 “(4) BENEFICIARY FINANCIAL REQUIRE-
5 MENTS.—

6 “(A) NO BENEFICIARY FINANCIAL RE-
7 QUIREMENT.—If the plan or coverage does not
8 include a beneficiary financial requirement (as
9 defined in subparagraph (C)) on substantially
10 all medical and surgical benefits within a cat-
11 egory of items and services (specified under
12 paragraph (3)(C)), the plan or coverage may
13 not impose such a beneficiary financial require-
14 ment on mental health or substance-related dis-
15 order benefits for items and services within
16 such category.

17 “(B) BENEFICIARY FINANCIAL REQUIRE-
18 MENT.—

19 “(i) TREATMENT OF DEDUCTIBLES,
20 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
21 NANCIAL REQUIREMENTS.—If the plan or
22 coverage includes a deductible, a limitation
23 on out-of-pocket expenses, or similar bene-
24 ficiary financial requirement that does not
25 apply separately to individual items and

1 services on substantially all medical and
2 surgical benefits within a category of items
3 and services (as specified in paragraph
4 (3)(C)), the plan or coverage shall apply
5 such requirement (or, if there is more than
6 one such requirement for such category of
7 items and services, the predominant re-
8 quirement for such category) both to med-
9 ical and surgical benefits within such cat-
10 egory and to mental health and substance-
11 related disorder benefits within such cat-
12 egory and shall not distinguish in the ap-
13 plication of such requirement between such
14 medical and surgical benefits and such
15 mental health and substance-related dis-
16 order benefits.

17 “(ii) OTHER FINANCIAL REQUIRE-
18 MENTS.—If the plan or coverage includes a
19 beneficiary financial requirement not de-
20 scribed in clause (i) on substantially all
21 medical and surgical benefits within a cat-
22 egory of items and services, the plan or
23 coverage may not impose such financial re-
24 quirement on mental health or substance-
25 related disorder benefits for items and

1 services within such category in a way that
2 results in greater out-of-pocket expenses to
3 the participant or beneficiary than the pre-
4 dominant beneficiary financial requirement
5 applicable to medical and surgical benefits
6 for items and services within such cat-
7 egory.

8 “(iii) CONSTRUCTION.—Nothing in
9 this subparagraph shall be construed as
10 prohibiting the plan or coverage from
11 waiving the application of any deductible
12 for mental health benefits or substance-re-
13 lated disorder benefits or both.

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

25 (2) in subsection (b)—

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

4 (B) by striking “; or” and inserting a pe-
5 riod; and

6 (C) by striking paragraph (2).

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

10 (1) by striking “mental health benefits” and in-
11 sserting “mental health or substance-related disorder
12 benefits” each place it appears; and

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

14 (A) by striking “MENTAL HEALTH BENE-
15 FITS” and inserting “MENTAL HEALTH AND
16 SUBSTANCE-RELATED DISORDER BENEFITS”;

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

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

24 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
25 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of

1 such section, as amended by subsection (a)(1), is further
2 amended by adding at the end the following new para-
3 graph:

4 “(5) AVAILABILITY OF PLAN INFORMATION.—

5 The criteria for medical necessity determinations
6 made under the plan with respect to mental health
7 and substance-related disorder benefits (or the
8 health insurance coverage offered in connection with
9 the plan with respect to such benefits) shall be made
10 available in accordance with regulations by the plan
11 administrator (or the health insurance issuer offer-
12 ing such coverage) to any current or potential par-
13 ticipant, beneficiary, or contracting provider upon
14 request. The reason for any denial under the plan
15 (or coverage) of reimbursement or payment for serv-
16 ices with respect to mental health and substance-re-
17 lated disorder benefits in the case of any participant
18 or beneficiary shall, upon request, be made available
19 in accordance with regulations by the plan adminis-
20 trator (or the health insurance issuer offering such
21 coverage) to the participant or beneficiary.”.

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

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

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

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

19 “(i) IN GENERAL.—In the case of a
20 plan or coverage that provides both med-
21 ical and surgical benefits and mental
22 health or substance-related disorder bene-
23 fits, if medical and surgical benefits are
24 provided for substantially all items and
25 services in a category specified in clause

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

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

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

1 gency condition relating to mental
2 health or substance-related disorders).

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

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

9 (e) CONSTRUCTION.—Subsection (a) of such section
10 is further amended by adding at the end the following new
11 paragraph:

12 “(7) CONSTRUCTION.—Nothing in this section
13 shall be construed to limit a group health plan (or
14 health insurance offered in connection with such a
15 plan) from managing the provision of medical, sur-
16 gical, mental health or substance-related disorder
17 benefits through any of the following methods:

18 “(A) the application of utilization review;

19 “(B) the application of authorization or
20 management practices;

21 “(C) the application of medical necessity
22 and appropriateness criteria; or

23 “(D) other processes intended to ensure
24 that beneficiaries receive appropriate care and

1 medically necessary services for covered bene-
2 fits;
3 to the extent such methods are recognized both by
4 industry and by providers and are not prohibited
5 under applicable State laws.”.

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

9 “(2) INCREASED COST EXEMPTION.—

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

1 shall apply to the plan (or coverage) for 1 plan
2 year.

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

7 “(i) 2 percent in the case of the first
8 plan year which begins after the effective
9 date of the amendments made by section
10 101 of the Paul Wellstone Mental Health
11 and Addiction Equity Act of 2007; and

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

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

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

1 made after such plan (or coverage) has com-
2 plied with this section for the first 6 months of
3 the plan year involved.

4 “(E) NOTIFICATION.—An election to mod-
5 ify coverage of mental health and substance-re-
6 lated disorder benefits as permitted under this
7 paragraph shall be treated as a material modi-
8 fication in the terms of the plan as described in
9 section 102(a) and notice of which shall be pro-
10 vided a reasonable period in advance of the
11 change.

12 “(F) NOTIFICATION OF APPROPRIATE
13 AGENCY.—

14 “(i) IN GENERAL.—A group health
15 plan that, based on upon a certification de-
16 scribed under subparagraph (C), qualifies
17 for an exemption under this paragraph,
18 and elects to implement the exemption,
19 shall notify the Department of Labor of
20 such election.

21 “(ii) REQUIREMENT.—A notification
22 under clause (i) shall include—

23 “(I) a description of the number
24 of covered lives under the plan (or
25 coverage) involved at the time of the

1 notification, and as applicable, at the
2 time of any prior election of the cost-
3 exemption under this paragraph by
4 such plan (or coverage);

5 “(II) for both the plan year upon
6 which a cost exemption is sought and
7 the year prior, a description of the ac-
8 tual total costs of coverage with re-
9 spect to medical and surgical benefits
10 and mental health and substance-re-
11 lated disorder benefits under the plan;
12 and

13 “(III) for both the plan year
14 upon which a cost exemption is sought
15 and the year prior, the actual total
16 costs of coverage with respect to men-
17 tal health and substance-related dis-
18 order benefits under the plan.

19 “(iii) CONFIDENTIALITY.—A notifica-
20 tion under clause (i) shall be confidential.
21 The Department of Labor shall make
22 available, upon request to the appropriate
23 committees of Congress and on not more
24 than an annual basis, an anonymous

1 itemization of such notifications, that in-
2 cludes—

3 “(I) a breakdown of States by
4 the size and any type of employers
5 submitting such notification; and

6 “(II) a summary of the data re-
7 ceived under clause (ii).

8 “(G) NO IMPACT ON APPLICATION OF
9 STATE LAW.—The fact that a plan or coverage
10 is exempt from the provisions of this section
11 under subparagraph (A) shall not affect the ap-
12 plication of State law to such plan or cov-
13 erage.”.

14 (g) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
15 ERS.—Subsection (c)(1)(B) of such section is amended—

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

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

22 (h) ELIMINATION OF SUNSET PROVISION.—Such sec-
23 tion is amended by striking out subsection (f).

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

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

5 “(1) IN GENERAL.—This part shall not be con-
6 strued to supersede any provision of State law which
7 establishes, implements, or continues in effect any
8 consumer protections, benefits, methods of access to
9 benefits, rights, external review programs, or rem-
10 edies solely relating to health insurance issuers in
11 connection with group health insurance coverage (in-
12 cluding benefit mandates or regulation of group
13 health plans of 50 or fewer employees) except to the
14 extent that such provision prevents the application
15 of a requirement of this part.

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

20 “(3) OTHER STATE LAWS.—Nothing in this sec-
21 tion shall be construed to exempt or relieve any per-
22 son from any laws of any State not solely related to
23 health insurance issuers in connection with group
24 health coverage insofar as they may now or here-

1 after relate to insurance, health plans, or health cov-
2 erage.’”.

3 (j) CONFORMING AMENDMENTS TO HEADING.—

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

6 **“SEC. 712.”.**

7 (2) CLERICAL AMENDMENT.—The table of con-
8 tents in section 1 of such Act is amended by striking
9 the item relating to section 712 and inserting the
10 following new item:

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

11 (k) EFFECTIVE DATE.—

12 (1) IN GENERAL.—The amendments made by
13 this section shall apply with respect to plan years be-
14 ginning on or after January 1, 2008.

15 (2) SPECIAL RULE FOR COLLECTIVE BAR-
16 GAINING AGREEMENTS.—In the case of a group
17 health plan maintained pursuant to one or more col-
18 lective bargaining agreements between employee rep-
19 resentatives and one or more employers ratified be-
20 fore the date of the enactment of this Act, the
21 amendments made by this section shall not apply to
22 plan years beginning before the later of—

23 (A) the date on which the last of the col-
24 lective bargaining agreements relating to the
25 plan terminates (determined without regard to

1 any extension thereof agreed to after the date
2 of the enactment of this Act), or

3 (B) January 1, 2010.

4 For purposes of subparagraph (A), any plan amend-
5 ment made pursuant to a collective bargaining
6 agreement relating to the plan which amends the
7 plan solely to conform to any requirement imposed
8 under an amendment under this section shall not be
9 treated as a termination of such collective bar-
10 gaining agreement.

11 (l) DOL ANNUAL SAMPLE COMPLIANCE.—The Sec-
12 retary of Labor shall annually sample and conduct random
13 audits of group health plans (and health insurance cov-
14 erage offered in connection with such plans) in order to
15 determine their compliance with the amendments made by
16 this Act and shall submit to the appropriate committees
17 of Congress an annual report on such compliance with
18 such amendments.

19 (m) ASSISTANCE TO PARTICIPANTS AND BENE-
20 FICIARIES.—The Secretary of Labor shall provide assist-
21 ance to participants and beneficiaries of group health
22 plans with any questions or problems with compliance with
23 the requirements of this Act. The Secretary shall notify
24 participants and beneficiaries when they can obtain assist-
25 ance from State consumer and insurance agencies and the

1 Secretary shall coordinate with State agencies to ensure
2 that participants and beneficiaries are protected and af-
3 forded the rights provided under this Act.

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

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

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

12 “(3) TREATMENT LIMITS.—

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

23 “(B) TREATMENT LIMIT.—If the plan or
24 coverage includes a treatment limit on substan-
25 tially all medical and surgical benefits in any

1 category of items or services, the plan or cov-
2 erage may not impose such a treatment limit on
3 mental health and substance-related disorder
4 benefits for items and services within such cat-
5 egory that are more restrictive than the pre-
6 dominant treatment limit that is applicable to
7 medical and surgical benefits for items and
8 services within such category.

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

21 “(i) INPATIENT, IN-NETWORK.—Items
22 and services furnished on an inpatient
23 basis and within a network of providers es-
24 tablished or recognized under such plan or
25 coverage.

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

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

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

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

23 “(E) PREDOMINANCE.—For purposes of
24 this subsection, a treatment limit or financial
25 requirement with respect to a category of items

1 and services is considered to be predominant if
2 it is the most common or frequent of such type
3 of limit or requirement with respect to such cat-
4 egory of items and services.

5 “(4) BENEFICIARY FINANCIAL REQUIRE-
6 MENTS.—

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

18 “(B) BENEFICIARY FINANCIAL REQUIRE-
19 MENT.—

20 “(i) TREATMENT OF DEDUCTIBLES,
21 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
22 NANCIAL REQUIREMENTS.—If the plan or
23 coverage includes a deductible, a limitation
24 on out-of-pocket expenses, or similar bene-
25 ficiary financial requirement that does not

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

17 “(ii) OTHER FINANCIAL REQUIRE-
18 MENTS.—If the plan or coverage includes a
19 beneficiary financial requirement not de-
20 scribed in clause (i) on substantially all
21 medical and surgical benefits within a cat-
22 egory of items and services, the plan or
23 coverage may not impose such financial re-
24 quirement on mental health and substance-
25 related disorder benefits for items and

1 services within such category in a way that
2 is more costly to the participant or bene-
3 ficiary than the predominant beneficiary fi-
4 nancial requirement applicable to medical
5 and surgical benefits for items and services
6 within such category.

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

18 (2) in subsection (b)—

19 (A) by striking “construed—” and all that
20 follows through “(1) as requiring” and insert-
21 ing “construed as requiring”;

22 (B) by striking “; or” and inserting a pe-
23 riod; and

24 (C) by striking paragraph (2).

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

4 (1) by striking “mental health benefits” and in-
5 serting “mental health and substance-related dis-
6 order benefits” each place it appears; and

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

8 (A) by striking “MENTAL HEALTH BENE-
9 FITS” and inserting “MENTAL HEALTH AND
10 SUBSTANCE-RELATED DISORDER BENEFITS”;

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

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

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

23 “(5) AVAILABILITY OF PLAN INFORMATION.—
24 The criteria for medical necessity determinations
25 made under the plan with respect to mental health

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

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

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

20 “(A) MINIMUM SCOPE OF MENTAL
21 HEALTH AND SUBSTANCE-RELATED DISORDER
22 BENEFITS.—In the case of a group health plan
23 (or health insurance coverage offered in connec-
24 tion with such a plan) that provides any mental
25 health and substance-related disorder benefits,

1 the plan or coverage shall include benefits for
2 any mental health condition or substance-re-
3 lated disorder for which benefits are provided
4 under the benefit plan option offered under
5 chapter 89 of title 5, United States Code, with
6 the highest average enrollment as of the begin-
7 ning of the most recent year beginning on or
8 before the beginning of the plan year involved.

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

11 “(i) IN GENERAL.—In the case of a
12 plan or coverage that provides both med-
13 ical and surgical benefits and mental
14 health and substance-related disorder bene-
15 fits, if medical and surgical benefits are
16 provided for substantially all items and
17 services in a category specified in clause
18 (ii) furnished outside any network of pro-
19 viders established or recognized under such
20 plan or coverage, the mental health and
21 substance-related disorder benefits shall
22 also be provided for items and services in
23 such category furnished outside any net-
24 work of providers established or recognized

1 under such plan or coverage in accordance
2 with the requirements of this section.

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

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

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

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

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

7 “(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 **“SEC. 2705.”**

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

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

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

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

24 “(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (2) in subsection (b)—

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

7 (B) by striking “; or” and inserting a pe-
8 riod; and

9 (C) by striking paragraph (2).

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

13 (1) by striking “mental health benefits” and in-
14 serting “mental health and substance-related dis-
15 order benefits” each place it appears; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

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

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

6 “(1) SMALL EMPLOYER EXEMPTION.—

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

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

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

3 (h) CONFORMING AMENDMENTS TO HEADING.—

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

6 **“SEC. 9812.”**

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

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

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

15 **SEC. 5. STUDIES AND REPORTS.**

16 (a) IMPLEMENTATION OF ACT.—

17 (1) GAO STUDY.—The Comptroller General of
18 the United States shall conduct a study that evalu-
19 ates the effect of the implementation of the amend-
20 ments made by this Act on—

21 (A) the cost of health insurance coverage;

22 (B) access to health insurance coverage

23 (including the availability of in-network pro-
24 viders);

25 (C) the quality of health care;

1 (D) Medicare, Medicaid, and State and
2 local mental health and substance abuse treat-
3 ment spending;

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

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

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

20 (H) other matters as determined appro-
21 priate by the Comptroller General.

22 (2) REPORT.—Not later than 2 years after the
23 date of enactment of this Act, the Comptroller Gen-
24 eral shall prepare and submit to the appropriate

1 committees of the Congress a report containing the
2 results of the study conducted under paragraph (1).

3 (b) GAO REPORT ON UNIFORM PATIENT PLACE-
4 MENT CRITERIA.—Not later than 18 months after the
5 date of the enactment of this Act, the Comptroller General
6 shall submit to the appropriate committees of each House
7 of the Congress a report on availability of uniform patient
8 placement criteria for mental health and substance-related
9 disorders that could be used by group health plans and
10 health insurance issuers to guide determinations of med-
11 ical necessity and the extent to which health plans utilize
12 such criteria. If such criteria do not exist, the report shall
13 include recommendations on a process for developing such
14 criteria.

15 (c) DOL BIENNIAL REPORT ON OBSTACLES IN OB-
16 TAINING COVERAGE.—Every two years, the Secretary of
17 Labor, in consultation with the Secretaries of Health and
18 Human Services and the Treasury, shall submit to the ap-
19 propriate committees of each House of the Congress a re-
20 port on obstacles that individuals face in obtaining mental
21 health and substance-related disorder care under their
22 health plans.