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:

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. 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 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 (including an emergency condition relating to mental health and substance-related disorders).

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

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

it is the most common or frequent of such type of limit or requirement with respect to such category of items and services.

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as prohibiting the plan or coverage from waiving the application of any deductible for mental health benefits or substance-related disorder benefits or both.

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

(C) by striking '', but does not include benefits with respect to treatment of 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 in accordance with regulations 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 in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.''.

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

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

''(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition and 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 or substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified in clause

(ii) furnished outside any network of providers established or recognized under such plan or coverage, the mental health and substance-related disorder benefits shall also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan or coverage in accordance with the requirements of this section.

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

''(I) EMERGENCY.—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (including an emer-

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

''(7) CONSTRUCTION.—Nothing in this section shall be construed to limit a group health plan (or health insurance offered in connection with such a plan) from managing the provision of medical, surgical, mental health or substance-related disorder benefits through any of the following methods:

''(A) the application of utilization review;

''(B) the application of authorization or management practices;

''(C) the application of medical necessity and appropriateness criteria; or

''(D) other processes intended to ensure that beneficiaries receive appropriate care and

medically necessary services for covered benefits;

to the extent such methods are recognized both by industry and by providers and are not prohibited under applicable State laws.''.

(f) 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 effective date of the amendments made by section 101 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 and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.

''(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 upon 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.''.

(g) 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''.

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

(i) 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 here-

after relate to insurance, health plans, or health coverage.' ''.

(j) CONFORMING AMENDMENTS TO HEADING.—

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

"SEC. 712.".

(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.''.

(k) EFFECTIVE DATE.—

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

(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, 2010.

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

(l) 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.

(m) 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 when 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.—

"(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 com-

plied 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.''.

(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 net-

work 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 fi-

nancial 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 out-

side 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 fol-

lowing 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.".

(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. 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 the appropriate committees of 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 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 that individuals face in obtaining mental health and substance-related disorder care under their health plans.