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(Original Signature of Member)

110TH CONGRESS
1ST SESSION

H. R.

To amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

IN THE HOUSE OF REPRESENTATIVES

Mr. KENNEDY (for himself and [see ATTACHED LIST of cosponsors]) introduced the following bill; which was referred to the Committee on

A BILL

To amend section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

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

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:

15 “(3) **TREATMENT LIMITS.**—

16 “(A) **NO TREATMENT LIMIT.**—If the plan
17 or coverage does not include a treatment limit
18 (as defined in subparagraph (D)) on substan-
19 tially all medical and surgical benefits in any
20 category of items or services, the plan or cov-
21 erage may not impose any treatment limit on
22 mental health and substance-related disorder

1 benefits that are classified in the same category
2 of items or services.

3 “(B) TREATMENT LIMIT.—If the plan or
4 coverage includes a treatment limit 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 such a treatment limit on
8 mental health and substance-related disorder
9 benefits for items and services within such cat-
10 egory that are more restrictive than the pre-
11 dominant treatment limit that is applicable to
12 medical and surgical benefits for items and
13 services within such category.

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

1 “(i) INPATIENT, IN-NETWORK.—Items
2 and services furnished on an inpatient
3 basis and within a network of providers es-
4 tablished or recognized under such plan or
5 coverage.

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

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

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

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

1 lar limit on the duration or scope of treatment
2 under the plan or coverage.

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

10 “(4) BENEFICIARY FINANCIAL REQUIRE-
11 MENTS.—

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

23 “(B) BENEFICIARY FINANCIAL REQUIRE-
24 MENT.—

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

24 “(ii) OTHER FINANCIAL REQUIRE-
25 MENTS.—If the plan or coverage includes a

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

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 and substance-related dis-
12 order 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 by the plan administrator (or the health in-
11 surance issuer offering such coverage) to any cur-
12 rent or potential participant, beneficiary, or con-
13 tracting provider upon request. The reason for any
14 denial under the plan (or coverage) of reimburse-
15 ment or payment for services with respect to mental
16 health and substance-related disorder benefits in the
17 case of any participant or beneficiary shall, upon re-
18 quest, be made available by the plan administrator
19 (or the health insurance issuer offering such cov-
20 erage) to the participant or beneficiary.”.

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

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

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

15 “(B) EQUITY IN COVERAGE OF OUT-OF-
16 NETWORK BENEFITS.—

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

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

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

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

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

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

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

10 “(2) INCREASED COST EXEMPTION.—

11 “(A) IN GENERAL.—With respect to a
12 group health plan (or health insurance coverage
13 offered in connection with such a plan), if the
14 application of this section to such plan (or cov-
15 erage) results in an increase for the plan year
16 involved of the actual total costs of coverage
17 with respect to medical and surgical benefits
18 and mental health and substance-related dis-
19 order benefits under the plan (as determined
20 and certified under subparagraph (C)) by an
21 amount that exceeds the applicable percentage
22 described in subparagraph (B) of the actual
23 total plan costs, the provisions of this section
24 shall not apply to such plan (or coverage) dur-
25 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 date of
9 the enactment of the Paul Wellstone Men-
10 tal Health and Addiction Equity Act of
11 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 by a qualified actuary
18 who is a member in good standing of the Amer-
19 ican Academy of Actuaries. Such determina-
20 tions shall be certified by the actuary and be
21 made available to the general public.

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

1 determinations under subparagraph (A) shall be
2 made after such plan (or coverage) has com-
3 plied with this section for the first 6 months of
4 the plan year involved.

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

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

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

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

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

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

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

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

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

12 (i) CONFORMING AMENDMENTS TO HEADING.—

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

15 **“SEC. 712. Equity in mental health and substance-related dis-**
16 **order benefits.”.**

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

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

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

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

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

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

9 “(3) TREATMENT LIMITS.—

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

20 “(B) TREATMENT LIMIT.—If the plan or
21 coverage includes a treatment limit on substan-
22 tially all medical and surgical benefits in any
23 category of items or services, the plan or cov-
24 erage may not impose such a treatment limit on
25 mental health and substance-related disorder
26 benefits for items and services within such cat-

1 egory that are more restrictive than the pre-
2 dominant treatment limit that is applicable to
3 medical and surgical benefits for items and
4 services within such category.

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

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

22 “(ii) INPATIENT, OUT-OF-NETWORK.—
23 Items and services furnished on an inpa-
24 tient basis and outside any network of pro-

1 viders established or recognized under such
2 plan or coverage.

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

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

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

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

1 of limit or requirement with respect to such cat-
2 egory of items and services.

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

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

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

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

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

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

1 beneficiary than the predominant beneficiary fi-
2 nancial requirement applicable to medical
3 and surgical benefits for items and services
4 within such category.

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

16 (2) in subsection (b)—

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

20 (B) by striking “; or” and inserting a pe-
21 riod; and

22 (C) by striking paragraph (2).

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

1 (1) by striking “mental health benefits” and in-
2 sserting “mental health and substance-related dis-
3 order benefits” each place it appears; and

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

5 (A) by striking “MENTAL HEALTH BENE-
6 FITS” and inserting “MENTAL HEALTH AND
7 SUBSTANCE-RELATED DISORDER BENEFITS”;

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

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

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

20 “(5) AVAILABILITY OF PLAN INFORMATION.—

21 The criteria for medical necessity determinations
22 made under the plan with respect to mental health
23 and substance-related disorder benefits (or the
24 health insurance coverage offered in connection with
25 the plan with respect to such benefits) shall be made

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

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

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

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

1 under the benefit plan option offered under
2 chapter 89 of title 5, United States Code, with
3 the highest average enrollment as of the begin-
4 ning of the most recent year beginning on or
5 before the beginning of the plan year involved.

6 “(B) EQUITY IN COVERAGE OF OUT-OF-
7 NETWORK BENEFITS.—

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

24 “(ii) CATEGORIES OF ITEMS AND
25 SERVICES.—For purposes of clause (i),

1 there shall be the following three categories
2 of items and services for benefits, whether
3 medical and surgical benefits or mental
4 health and substance-related disorder bene-
5 fits, and all medical and surgical benefits
6 and all mental health and substance-re-
7 lated disorder benefits shall be classified
8 into one of the following categories:

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

17 “(II) INPATIENT.—Items and
18 services not described in subclause (I)
19 furnished on an inpatient basis.

20 “(III) OUTPATIENT.—Items and
21 services not described in subclause (I)
22 furnished on an outpatient basis.”.

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

1 “(2) INCREASED COST EXEMPTION.—

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

19 “(B) APPLICABLE PERCENTAGE.—With re-
20 spect to a plan (or coverage), the applicable
21 percentage described in this paragraph shall
22 be—

23 “(i) 2 percent in the case of the first
24 plan year which begins after the date of
25 the enactment of the Paul Wellstone Men-

1 tal Health and Addiction Equity Act of
2 2007; and

3 “(ii) 1 percent in the case of each
4 subsequent plan year.

5 “(C) DETERMINATIONS BY ACTUARIES.—
6 Determinations as to increases in actual costs
7 under a plan (or coverage) for purposes of this
8 subsection shall be made by a qualified actuary
9 who is a member in good standing of the Amer-
10 ican Academy of Actuaries. Such determina-
11 tions shall be certified by the actuary and be
12 made available to the general public.

13 “(D) 6-MONTH DETERMINATIONS.—If a
14 group health plan (or a health insurance issuer
15 offering coverage in connection with such a
16 plan) seeks an exemption under this paragraph,
17 determinations under subparagraph (A) shall be
18 made after such plan (or coverage) has com-
19 plied with this section for the first 6 months of
20 the plan year involved.

21 “(E) NOTIFICATION.—A group health plan
22 under this part shall comply with the notice re-
23 quirement under section 712(c)(2)(E) of the
24 Employee Retirement Income Security Act of
25 1974 with respect to the a modification of men-

1 tal health and substance-related disorder bene-
2 fits as permitted under this paragraph as if
3 such section applied to such plan.”.

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

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

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

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

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

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

18 “(1) IN GENERAL.—Nothing in this section
19 shall be construed to preempt any State law that
20 provides greater consumer protections, benefits,
21 methods of access to benefits, rights or remedies
22 that are greater than the protections, benefits, meth-
23 ods of access to benefits, rights or remedies provided
24 under this section.

1 disorder benefits that are classified in the same
2 category of items or services.

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

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

1 “(i) INPATIENT, IN-NETWORK.—Items
2 and services furnished on an inpatient
3 basis and within a network of providers es-
4 tablished or recognized under such plan or
5 coverage.

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

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

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

21 “(D) TREATMENT LIMIT DEFINED.—For
22 purposes of this paragraph, the term ‘treatment
23 limit’ means, with respect to a plan, limitation
24 on the frequency of treatment, number of visits
25 or days of coverage, or other similar limit on

1 the duration or scope of treatment under the
2 plan.

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

10 “(4) BENEFICIARY FINANCIAL REQUIRE-
11 MENTS.—

12 “(A) NO BENEFICIARY FINANCIAL RE-
13 QUIREMENT.—If the plan does not include a
14 beneficiary financial requirement (as defined in
15 subparagraph (C)) on substantially all medical
16 and surgical benefits within a category of items
17 and services (specified in paragraph (3)(C)),
18 the plan may not impose such a beneficiary fi-
19 nancial requirement on mental health and sub-
20 stance-related disorder benefits for items and
21 services within such category.

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

24 “(i) TREATMENT OF DEDUCTIBLES,
25 OUT-OF-POCKET LIMITS, AND SIMILAR FI-

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

21 “(ii) OTHER FINANCIAL REQUIRE-
22 MENTS.—If the plan includes a beneficiary
23 financial requirement not described in
24 clause (i) on substantially all medical and
25 surgical benefits within a category of items

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

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

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

24 (B) by striking “; or” and inserting a pe-
25 riod; and

1 (C) by striking paragraph (2).

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

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

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

9 (A) by striking “MENTAL HEALTH BENE-
10 FITS” in the heading and inserting “MENTAL
11 HEALTH AND SUBSTANCE-RELATED DISORDER
12 BENEFITS”;

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

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

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

1 “(5) AVAILABILITY OF PLAN INFORMATION.—
2 The criteria for medical necessity determinations
3 made under the plan with respect to mental health
4 and substance-related disorder benefits shall be
5 made available by the plan administrator 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 of reimbursement or payment
9 for services with respect to mental health and sub-
10 stance-related disorder benefits in the case of any
11 participant or beneficiary shall, upon request, be
12 made available by the plan administrator to the par-
13 ticipant or beneficiary.”.

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

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

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

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

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

10 “(i) IN GENERAL.—In the case of a
11 plan that provides both medical and sur-
12 gical benefits and mental health and sub-
13 stance-related disorder benefits, if medical
14 and surgical benefits are provided for sub-
15 stantially all items and services in a cat-
16 egory specified in clause (ii) furnished out-
17 side any network of providers established
18 or recognized under such plan or coverage,
19 the mental health and substance-related
20 disorder benefits shall also be provided for
21 items and services in such category fur-
22 nished outside any network of providers es-
23 tablished or recognized under such plan in
24 accordance with the requirements of this
25 section.

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

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

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

22 “(III) OUTPATIENT.—Items and
23 services not described in subclause (I)
24 furnished on an outpatient basis.”.

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

4 “(2) INCREASED COST EXEMPTION.—

5 “(A) IN GENERAL.—With respect to a
6 group health plan, if the application of this sec-
7 tion to such plan results in an increase for the
8 plan year involved of the actual total costs of
9 coverage with respect to medical and surgical
10 benefits and mental health and substance-re-
11 lated disorder benefits under the plan (as deter-
12 mined and certified under subparagraph (C)) by
13 an amount that exceeds the applicable percent-
14 age described in subparagraph (B) of the actual
15 total plan costs, the provisions of this section
16 shall not apply to such plan during the fol-
17 lowing plan year, and such exemption shall
18 apply to the plan for 1 plan year.

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

22 “(i) 2 percent in the case of the first
23 plan year which begins after the date of
24 the enactment of the Paul Wellstone Men-

1 tal Health and Addiction Equity Act of
2 2007; and

3 “(ii) 1 percent in the case of each
4 subsequent plan year.

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

13 “(D) 6-MONTH DETERMINATIONS.—If a
14 group health plan seeks an exemption under
15 this paragraph, determinations under subpara-
16 graph (A) shall be made after such plan has
17 complied with this section for the first 6
18 months of the plan year involved.”.

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

22 “(1) SMALL EMPLOYER EXEMPTION.—

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

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

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

18 (h) CONFORMING AMENDMENTS TO HEADING.—

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

21 **“SEC. 9812. Equity in mental health and substance-related dis-
22 order benefits.”.**

23 (2) CLERICAL AMENDMENT.—The table of sec-
24 tions for subchapter B of chapter 100 of the Inter-
25 nal Revenue Code of 1986 is amended by striking

1 the item relating to section 9812 and inserting the
2 following new item:

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

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

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

8 (a) **IMPLEMENTATION OF ACT.**—

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

13 (A) the cost of health insurance coverage;

14 (B) access to health insurance coverage
15 (including the availability of in-network pro-
16 viders);

17 (C) the quality of health care;

18 (D) Medicare, Medicaid, and State and
19 local mental health and substance abuse treat-
20 ment spending;

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

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

4 (G) the use of medical management of
5 mental health and substance-related disorder
6 benefits and medical necessity determinations
7 by group health plans (and health insurance
8 issuers offering health insurance coverage in
9 connection with such plans) and timely access
10 by participants and beneficiaries to clinically-in-
11 dicated care for mental health and substance-
12 use disorders; and

13 (H) other matters as determined appro-
14 priate by the Comptroller General.

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

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

1 (c) UNIFORM PATIENT PLACEMENT CRITERIA.—Not
2 later than 18 months after the date of the enactment of
3 this Act, the Comptroller General shall submit to each
4 House of the Congress a report on availability of uniform
5 patient placement criteria for mental health and sub-
6 stance-related disorders that could be used by group
7 health plans and health insurance issuers to guide deter-
8 minations of medical necessity and the extent to which
9 health plans utilize such criteria. If such criteria do not
10 exist, the report shall include recommendations on a proc-
11 ess for developing such criteria.