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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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

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

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

''(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a

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

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

such section, as amended by subsection (a)(1), is further amended by adding at the end the following new paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

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

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

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

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

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

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

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

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

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

(i) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

egory 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 pro-

viders 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 bene-

ficiary 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 Men-

tal Health and Addiction Equity Act of 2007; and

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

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

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

''(E) NOTIFICATION.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the Employee Retirement Income Security Act of 1974 with respect to the a modification of men-

tal health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.''.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

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

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

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

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

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

the duration or scope of treatment under the plan.

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

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

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

''(i) TREATMENT OF DEDUCTIBLES, OUT-OF-POCKET LIMITS, AND SIMILAR FI-

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

''(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items

and services, the plan may not impose such financial requirement on mental health and substance-related disorder benefits for items and services within such category in a way that is more costly to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

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

(2) in subsection (b)—

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

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

(C) by striking paragraph (2).

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

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

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

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

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

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

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

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

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

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

''(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health and substance-related disorder benefits, the plan or coverage shall include benefits for

any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under chapter 89 of title 5, United States Code, with the highest average enrollment as of the beginning of the most recent year beginning on or before the beginning of the plan year involved.

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

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

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

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

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

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

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

''(2) INCREASED COST EXEMPTION.—

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

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

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

tal Health and Addiction Equity Act of 2007; and

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

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

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

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

''(1) SMALL EMPLOYER EXEMPTION.—

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

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

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

(h) CONFORMING AMENDMENTS TO HEADING.—

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

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

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by striking

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

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

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

SEC. 5. GOVERNMENT ACCOUNTABILITY OFFICE STUDIES AND REPORTS.

(a) IMPLEMENTATION OF ACT.—

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

(A) the cost of health insurance coverage;

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

(C) the quality of health care;

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

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

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

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

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

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

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

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