PROPOSED MENTAL HEALTH PARITY BILL CHART

UPDATED JULY 25, 2008

Issue	Senate Bill (S. 558) [August 2, 2007 version]	House Bill (H.R. 1424)	Proposed Bill [tentative agreement]
1. Requirement for mental health and substance use disorder parity	• Prohibits applying financial requirements or treatment limitations that are more restrictive than the financial requirements and treatment limits applied to substantially all medical and surgical benefits. • Financial requirements include co-payments, deductibles, coinsurance, out-of-pocket expenses. Treatment limits on the frequency of treatment, number of visits, days of coverage, or other similar limits.	• Prohibits treatment limitations and financial requirements on mental health and substance related disorders that are more restrictive than the predominant (most common or frequent) limits applied to substantially all medical and surgical benefits. • Financial requirements include co-payments, deductibles, coinsurance, out-of-pocket expenses. Treatment limits include frequency, number of visits, days of coverage, or other similar limits.	• Amends and preserves current law by adding new requirements to Part 7 of ERISA, Public Health Service Act and Internal Revenue Code, including: • Prohibits applying financial requirements or treatment limitations to mental health or substance use disorders that are more restrictive than the predominant (most common or frequent) financial requirements or treatment limitations applied to substantially all medical and surgical benefits. • Financial requirements include deductibles, co-payments, coinsurance and out-of pocket expenses. Treatment limits include frequency, number of visits, days of coverage, other similar limits. • Existing law's parity requirements for annual and lifetime limits are retained.

Issue	Senate Bill (S. 558) [August 2, 2007 version]	House Bill (H.R. 1424)	Proposed Bill [tentative agreement]
2. Exemptions	• Cost- 1 year optional exemption if cost of coverage increases after 6 months by more than 2% in the first year and 1 % in following years. Actuary must certify. • Small employers with 2-50 employees.	• Cost- 1 year optional exemption if cost of coverage increases after 6 months by more than 2% the first year and 1% in following years. Actuary must certify. • Small employers with 1-50 employees.	• Cost – 1 year optional exemption if after 6 months cost of coverage increases by more than 2 % in first year & 1% in following years. Actuary must certify. • Small employers with 2-50 employees.
3. Notice	• Notice to federal agency required after opting-out under cost exemption and opt-out is a material modification, which requires notice to participants after opt-out.	• Notice to participants and agency required before opting-out under cost exemption.	• Prompt notice to federal and state agencies & participants is required under cost exception. Note: though unspecified, notice to participants will be required prior to effective date of opt-out by the plan.
4. Definition of mental health benefits subject to parity requirement	• Defines mental health benefits to mean "benefits with respect to mental health services (including substance abuse disorder treatment) as defined under the terms of the plan or coverage, and when applicable as may be defined under State law when applicable to health insurance coverage." • Therefore, the term "mental health" benefits also includes substance abuse benefits for purposes of the legislation and State law may continue to define what benefits a fully insured plan may be required to cover, but not a self-insured plan.	• Requires group health plans or health insurance coverage that provide "any" mental health and substance abuse benefits to provide the same benefits for mental health and substance abuse as the highest average enrollment plan offered to federal employees. • All plans offered to federal employees are required to provide benefits for all mental health and substance abuse disorders which are listed in the diagnostic manual for such conditions, which is currently the DSM-IV manual.	• Defines mental health benefits to mean "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law." • Defines substance use disorder benefits to mean "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State Law." • Term "mental health" benefits includes substance use benefits for purposes of the legislation and State law may continue to define what benefits a fully insured plan may be required to cover, but not a self-insured plan.

Issue	Senate Bill (S. 558) [August 2, 2007 version]	House Bill (H.R. 1424)	Proposed Bill [tentative agreement]
5. Protection of plan medical management practices	• Includes a rule of construction to protect a plan's ability to manage mental health benefits, make medical necessity and appropriateness determinations and the contracting and use of networks of participating providers.	• Includes no provision to protect plan medical management practices. • Requires plans to make available their criteria for medical necessity determinations and the reason for any denial of any reimbursement or payment for services for mental health or substance abuse benefits.	• No provision that prohibits plan medical management practices or mandates parity in medical management. • Includes rule of construction that Act does not affect "terms and conditions" of plans to the extent that they do not conflict with the parity requirements, which should protect medical necessity provisions. • Requires plans to make available their criteria for medical necessity determinations and the reason for any denial of any reimbursement or payment for services for mental health or substance abuse benefits.
6. Out-of-network coverage	• If a plan provides out-of-network coverage, parity rules shall apply separately to any in-network and out-of-network benefits. Note: did not require plan to provide out-of-network coverage for mental health conditions, but if it did so, parity requirements would apply.	• Requires plans to provide out-of-network coverage for mental health and substance abuse benefits if the plan provides out-of-network coverage for medical and surgical benefits in any of three categories: emergency care, inpatient care or outpatient care.	• Plan must provide out-of-network coverage for mental health and substance use disorders in a manner consistent with the parity requirement if out-of-network coverage is provided for medical and surgical benefits. Other applicable plan terms and conditions, such as those related to medical management, would continue to apply.

Issue	Senate Bill (S. 558) [August 2, 2007 version]	House Bill (H.R. 1424)	Proposed Bill [tentative agreement]
7. Relationship to State laws and remedies	• Applies current law "HIPAA standard" which establishes the federal requirements as a floor and permits states to enact more extensive requirements for insured plans.	• States may enact "any State law that provides greater consumer protections, benefits, methods of access to benefits, rights or remedies" that are greater than those in H.R. 1424.	• Applies current law "HIPAA standard" which establishes the federal requirements as a floor and permits states to enact more extensive requirements for insured plans, provided that such laws do not conflict with federal law. • Applies current law ERISA remedy scheme to new mental health parity requirements.
8. Issuance of regulations and effective date	• Regulations to be issued within one year after date of enactment. • Provisions shall be effective the first plan year beginning on or after January 1 that begins more than one year after the date of enactment.	• No provision for the date of issuance of regulatory guidance. All provisions would be effective for plan years beginning on or after January 1, 2008. • For plans maintained pursuant to a collective bargaining agreement (CBA), the provisions shall be effective the later of Jan. 1, 2009 or the expiration of the CBA.	• Regulations shall be issued within one year after the date of enactment. • For plans maintained pursuant to a collective bargaining agreement (CBA), provision is effective by the later of Jan. 1, 2009 or the expiration of the CBA. • Provisions shall be effective for plan years beginning 1 year after date of enactment regardless of whether regulations are issued.

Issue	Senate Bill (S. 558) [August 2, 2007 version]	House Bill (H.R. 1424)	Proposed Bill [tentative agreement]
9. Audits and reports to Congress	• DOL and HHS shall conduct random compliance audits. • GAO shall complete a study and report to Congress within 2 years of enactment.	• DOL shall annually conduct random compliance audits and report findings to Congress. • Federal agencies shall submit a report to Congress every 2 years on obstacles to obtaining mental health coverage under health plans. • GAO shall complete a study and report to Congress within 18 months of enactment.	• DOL shall report on health plan compliance to Congress every two years. Report shall include results of any audits conducted. • DOL shall publish & disseminate guidance on compliance & consumer assistance. • GAO shall complete a study report to Congress within 3 years of enactment & every 2 years thereafter on coverage rates for mental health conditions and exclusions.

American Benefits Council
July 25, 2008