AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 1424, AS REPORTED

OFFERED BY ________

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

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

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

Sec. 1. Short title; table of contents.
Sec. 2. Amendments to the Employee Retirement Income Security Act of 1974.
Sec. 3. Amendments to the Public Health Service Act relating to the group market.
Sec. 4. Amendments to the Internal Revenue Code of 1986.
Sec. 5. Medicaid drug rebate.
Sec. 6. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.
Sec. 7. 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—

1 (1) in subsection (a), by adding at the end the
2 following new paragraphs:
3 "(3) TREATMENT LIMITS.—In the case of a
4 group health plan that provides both medical and
5 surgical benefits and mental health or substance-re-
6 lated disorder benefits—
7 "(A) NO TREATMENT LIMIT.—If the plan
8 or coverage does not include a treatment limit
9 (as defined in subparagraph (D)) on substan-
10 tially all medical and surgical benefits in any
11 category of items or services, the plan or cov-
12 erage may not impose any treatment limit on
13 mental health or substance-related disorder
14 benefits that are classified in the same category
15 of items or services.
16 "(B) TREATMENT LIMIT.—If the plan or
17 coverage includes a treatment limit on substan-
18 tially all medical and surgical benefits in any
19 category of items or services, the plan or cov-
20 erage may not impose such a treatment limit on
21 mental health or substance-related disorder
22 benefits for items and services within such cat-
23 egory that is more restrictive than the predomi-
24 nant treatment limit that is applicable to med-

1 ical and surgical benefits for items and services
2 within such category.
3 "(C) CATEGORIES OF ITEMS AND SERV-
4 ICES FOR APPLICATION OF TREATMENT LIMITS
5 AND BENEFICIARY FINANCIAL REQUIRE-
6 MENTS.—For purposes of this paragraph and
7 paragraph (4), there shall be the following five
8 categories of items and services for benefits,
9 whether medical and surgical benefits or mental
10 health and substance-related disorder benefits,
11 and all medical and surgical benefits and all
12 mental health and substance related benefits
13 shall be classified into one of the following cat-
14 egories:
15 "(i) INPATIENT, IN-NETWORK.—Items
16 and services not described in clause (v)
17 furnished on an inpatient basis and within
18 a network of providers established or rec-
19 ognized under such plan or coverage.
20 "(ii) INPATIENT, OUT-OF-NETWORK.—
21 Items and services not described in clause
22 (v) furnished on an inpatient basis and
23 outside any network of providers estab-
24 lished or recognized under such plan or
25 coverage.

1 “(iii) OUTPATIENT, IN-NETWORK.—
2 Items and services not described in clause
3 (v) furnished on an outpatient basis and
4 within a network of providers established
5 or recognized under such plan or coverage.
6 “(iv) OUTPATIENT, OUT-OF-NET-
7 WORK.—Items and services not described
8 in clause (v) furnished on an outpatient
9 basis and outside any network of providers
10 established or recognized under such plan
11 or coverage.
12 “(v) EMERGENCY CARE.—Items and
13 services, whether furnished on an inpatient
14 or outpatient basis or within or outside
15 any network of providers, required for the
16 treatment of an emergency medical condi-
17 tion (as defined in section 1867(e) of the
18 Social Security Act, including an emer-
19 gency condition relating to mental health
20 or substance-related disorders).
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.—In the case of a group health plan that
12 provides both medical and surgical benefits and
13 mental health or substance-related disorder bene-
14 fits—
15 "(A) NO BENEFICIARY FINANCIAL RE-
16 QUIREMENT.—If the plan or coverage does not
17 include a beneficiary financial requirement (as
18 defined in subparagraph (C)) on substantially
19 all medical and surgical benefits within a cat-
20 egory of items and services (specified under
21 paragraph (3)(C)), the plan or coverage may
22 not impose such a beneficiary financial require-
23 ment on mental health or substance-related dis-
24 order benefits for items and services within
25 such category.

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

1 "(ii) OTHER FINANCIAL REQUIRE-
2 MENTS.—If the plan or coverage includes a
3 beneficiary financial requirement not de-
4 scribed in clause (i) on substantially all
5 medical and surgical benefits within a cat-
6 egory of items and services, the plan or
7 coverage may not impose such financial re-
8 quirement on mental health or substance-
9 related disorder benefits for items and
10 services within such category in a way that
11 results in greater out-of-pocket expenses to
12 the participant or beneficiary than the pre-
13 dominant beneficiary financial requirement
14 applicable to medical and surgical benefits
15 for items and services within such cat-
16 egory.
17 "(C) BENEFICIARY FINANCIAL REQUIRE-
18 MENT DEFINED.—For purposes of this para-
19 graph, the term 'beneficiary financial require-
20 ment' includes, with respect to a plan or cov-
21 erage, any deductible, coinsurance, co-payment,
22 other cost sharing, and limitation on the total
23 amount that may be paid by a participant or
24 beneficiary with respect to benefits under the
25 plan or coverage, but does not include the appli-

1 cation of any aggregate lifetime limit or annual
2 limit.''; and
3 (2) in subsection (b)—
4 (A) by striking ''construed—'' and all that
5 follows through ''(1) as requiring'' and insert-
6 ing ''construed as requiring'';
7 (B) by striking ''; or'' and inserting a pe-
8 riod; and
9 (C) by striking paragraph (2).
10 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
11 BENEFITS AND REVISION OF DEFINITION.—Such section
12 is further amended—
13 (1) by striking ''mental health benefits'' each
14 place it appears (other than in any provision amend-
15 ed by paragraph (2)) and inserting ''mental health
16 or substance-related disorder benefits'',
17 (2) by striking ''mental health benefits'' each
18 place it appears in subsections (a)(1)(B)(i),
19 (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting
20 ''mental health and substance-related disorder bene-
21 fits'', and
22 (3) in subsection (e), by striking paragraph (4)
23 and inserting the following new paragraphs:
24 ''(4) MENTAL HEALTH BENEFITS.—The term
25 'mental health benefits' means benefits with respect

1 to services for mental health conditions, as defined
2 under the terms of the plan and in accordance with
3 applicable law, but does not include substance-re-
4 lated disorder benefits.
5 ''(5) SUBSTANCE-RELATED DISORDER BENE-
6 FITS.—The term 'substance-related disorder bene-
7 fits' means benefits with respect to services for sub-
8 stance-related disorders, as defined under the terms
9 of the plan and in accordance with applicable law.''.
10 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
11 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
12 such section, as amended by subsection (a)(1), is further
13 amended by adding at the end the following new para-
14 graph:
15 ''(5) AVAILABILITY OF PLAN INFORMATION.—
16 The criteria for medical necessity determinations
17 made under the plan with respect to mental health
18 and substance-related disorder benefits (or the
19 health insurance coverage offered in connection with
20 the plan with respect to such benefits) shall be made
21 available by the plan administrator (or the health in-
22 surance issuer offering such coverage) in accordance
23 with regulations to any current or potential partici-
24 pant, beneficiary, or contracting provider upon re-
25 quest. The reason for any denial under the plan (or

1 coverage) of reimbursement or payment for services
2 with respect to mental health and substance-related
3 disorder benefits in the case of any participant or
4 beneficiary shall, on request or as otherwise re-
5 quired, be made available by the plan administrator
6 (or the health insurance issuer offering such cov-
7 erage) to the participant or beneficiary in accord-
8 ance with regulations.''.
9 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
10 section (a) of such section is further amended by adding
11 at the end the following new paragraph:
12 ''(6) MINIMUM SCOPE OF COVERAGE AND EQ-
13 UITY IN OUT-OF-NETWORK BENEFITS.—
14 ''(A) MINIMUM SCOPE OF MENTAL
15 HEALTH AND SUBSTANCE-RELATED DISORDER
16 BENEFITS.—In the case of a group health plan
17 (or health insurance coverage offered in connec-
18 tion with such a plan) that provides any mental
19 health or substance-related disorder benefits,
20 the plan or coverage shall include benefits for
21 any mental health condition or substance-re-
22 lated disorder included in the most recent edi-
23 tion of the Diagnostic and Statistical Manual of
24 Mental Disorders published by the American
25 Psychiatric Association.

1 "(B) EQUITY IN COVERAGE OF OUT-OF-
2 NETWORK BENEFITS.—
3 "(i) IN GENERAL.—In the case of a
4 plan or coverage that provides both med-
5 ical and surgical benefits and mental
6 health or substance-related disorder bene-
7 fits, if medical and surgical benefits are
8 provided for substantially all items and
9 services in a category specified in clause
10 (ii) furnished outside any network of pro-
11 viders established or recognized under such
12 plan or coverage, the mental health and
13 substance-related disorder benefits shall
14 also be provided for items and services in
15 such category furnished outside any net-
16 work of providers established or recognized
17 under such plan or coverage in accordance
18 with the requirements of this section.
19 "(ii) CATEGORIES OF ITEMS AND
20 SERVICES.—For purposes of clause (i),
21 there shall be the following three categories
22 of items and services for benefits, whether
23 medical and surgical benefits or mental
24 health and substance-related disorder bene-
25 fits, and all medical and surgical benefits

1 and all mental health and substance-re-
2 lated disorder benefits shall be classified
3 into one of the following categories:
4 "(I) EMERGENCY.—Items and
5 services, whether furnished on an in-
6 patient or outpatient basis, required
7 for the treatment of an emergency
8 medical condition (as defined in sec-
9 tion 1867(e) of the Social Security
10 Act, including an emergency condition
11 relating to mental health or sub-
12 stance-related disorders).
13 "(II) INPATIENT.—Items and
14 services not described in subclause (I)
15 furnished on an inpatient basis.
16 "(III) OUTPATIENT.—Items and
17 services not described in subclause (I)
18 furnished on an outpatient basis.".
19 (e) REVISION OF INCREASED COST EXEMPTION.—
20 Paragraph (2) of subsection (c) of such section is amended
21 to read as follows:
22 "(2) INCREASED COST EXEMPTION.—
23 "(A) IN GENERAL.—With respect to a
24 group health plan (or health insurance coverage
25 offered in connection with such a plan), if the

1 application of this section to such plan (or cov-
2 erage) results in an increase for the plan year
3 involved of the actual total costs of coverage
4 with respect to medical and surgical benefits
5 and mental health and substance-related dis-
6 order benefits under the plan (as determined
7 and certified under subparagraph (C)) by an
8 amount that exceeds the applicable percentage
9 described in subparagraph (B) of the actual
10 total plan costs, the provisions of this section
11 shall not apply to such plan (or coverage) dur-
12 ing the following plan year, and such exemption
13 shall apply to the plan (or coverage) for 1 plan
14 year.
15 ''(B) APPLICABLE PERCENTAGE.—With re-
16 spect to a plan (or coverage), the applicable
17 percentage described in this paragraph shall
18 be—
19 ''(i) 2 percent in the case of the first
20 plan year to which this paragraph applies;
21 and
22 ''(ii) 1 percent in the case of each
23 subsequent plan year.
24 ''(C) DETERMINATIONS BY ACTUARIES.—
25 Determinations as to increases in actual costs

1 under a plan (or coverage) for purposes of this
2 subsection shall be made in writing and pre-
3 pared and certified by a qualified and licensed
4 actuary who is a member in good standing of
5 the American Academy of Actuaries. Such de-
6 terminations shall be made available by the
7 plan administrator (or health insurance issuer,
8 as the case may be) to the general public.

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

17 ''(E) NOTIFICATION.—An election to mod-
18 ify coverage of mental health and substance-re-
19 lated disorder benefits as permitted under this
20 paragraph shall be treated as a material modi-
21 fication in the terms of the plan as described in
22 section 102(a) and notice of which shall be pro-
23 vided a reasonable period in advance of the
24 change.

1 "(F) NOTIFICATION OF APPROPRIATE
2 AGENCY.—
3 "(i) IN GENERAL.—A group health
4 plan that, based on a certification de-
5 scribed under subparagraph (C), qualifies
6 for an exemption under this paragraph,
7 and elects to implement the exemption,
8 shall notify the Department of Labor of
9 such election.
10 "(ii) REQUIREMENT.—A notification
11 under clause (i) shall include—
12 "(I) a description of the number
13 of covered lives under the plan (or
14 coverage) involved at the time of the
15 notification, and as applicable, at the
16 time of any prior election of the cost-
17 exemption under this paragraph by
18 such plan (or coverage);
19 "(II) for both the plan year upon
20 which a cost exemption is sought and
21 the year prior, a description of the ac-
22 tual total costs of coverage with re-
23 spect to medical and surgical benefits
24 and mental health and substance-re-

1 lated disorder benefits under the plan;
2 and
3 "(III) for both the plan year
4 upon which a cost exemption is sought
5 and the year prior, the actual total
6 costs of coverage with respect to men-
7 tal health and substance-related dis-
8 order benefits under the plan.
9 "(iii) CONFIDENTIALITY.—A notifica-
10 tion under clause (i) shall be confidential.
11 The Department of Labor shall make
12 available, upon request to the appropriate
13 committees of Congress and on not more
14 than an annual basis, an anonymous
15 itemization of such notifications, that in-
16 cludes—
17 "(I) a breakdown of States by
18 the size and any type of employers
19 submitting such notification; and
20 "(II) a summary of the data re-
21 ceived under clause (ii).
22 "(G) NO IMPACT ON APPLICATION OF
23 STATE LAW.—The fact that a plan or coverage
24 is exempt from the provisions of this section

1 under subparagraph (A) shall not affect the ap-
2 plication of State law to such plan or coverage.
3 "(H) CONSTRUCTION.—Nothing in this
4 paragraph shall be construed as preventing a
5 group health plan (or health insurance coverage
6 offered in connection with such a plan) from
7 complying with the provisions of this section
8 notwithstanding that the plan or coverage is not
9 required to comply with such provisions due to
10 the application of subparagraph (A).".
11 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
12 ERS.—Subsection (c)(1)(B) of such section is amended—
13 (1) by inserting "(or 1 in the case of an em-
14 ployer residing in a State that permits small groups
15 to include a single individual)" after "at least 2" the
16 first place it appears; and
17 (2) by striking "and who employs at least 2 em-
18 ployees on the first day of the plan year".
19 (g) ELIMINATION OF SUNSET PROVISION.—Such sec-
20 tion is amended by striking subsection (f).
21 (h) CLARIFICATION REGARDING PREEMPTION.—
22 Such section is further amended by inserting after sub-
23 section (e) the following new subsection:
24 "(f) PREEMPTION, RELATION TO STATE LAWS.—

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

12 "(2) CONTINUED PREEMPTION WITH RESPECT
13 TO GROUP HEALTH PLANS.—Nothing in this section
14 shall be construed to affect or modify the provisions
15 of section 514 with respect to group health plans.

16 "(3) OTHER STATE LAWS.—Nothing in this sec-
17 tion shall be construed to exempt or relieve any per-
18 son from any laws of any State not solely related to
19 health insurance issuers in connection with group
20 health coverage insofar as they may now or here-
21 after relate to insurance, health plans, or health cov-
22 erage.' ".

23 (i) CONFORMING AMENDMENTS TO HEADING.—

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

1 **"SEC. 712. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**
2 **RELATED DISORDER BENEFITS.".**

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

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

7 (j) EFFECTIVE DATE.—
8 (1) IN GENERAL.—The amendments made by
9 this section shall apply with respect to plan years be-
10 ginning on or after January 1, 2009.
11 (2) SPECIAL RULE FOR COLLECTIVE BAR-
12 GAINING AGREEMENTS.—In the case of a group
13 health plan maintained pursuant to one or more col-
14 lective bargaining agreements between employee rep-
15 resentatives and one or more employers ratified be-
16 fore the date of the enactment of this Act, the
17 amendments made by this section shall not apply to
18 plan years beginning before the later of—
19 (A) the date on which the last of the col-
20 lective bargaining agreements relating to the
21 plan terminates (determined without regard to
22 any extension thereof agreed to after the date
23 of the enactment of this Act), or
24 (B) January 1, 2009.

1 For purposes of subparagraph (A), any plan amend-
2 ment made pursuant to a collective bargaining
3 agreement relating to the plan which amends the
4 plan solely to conform to any requirement added by
5 this section shall not be treated as a termination of
6 such collective bargaining agreement.

7 (k) DOL ANNUAL SAMPLE COMPLIANCE.—The Sec-
8 retary of Labor shall annually sample and conduct random
9 audits of group health plans (and health insurance cov-
10 erage offered in connection with such plans) in order to
11 determine their compliance with the amendments made by
12 this Act and shall submit to the appropriate committees
13 of Congress an annual report on such compliance with
14 such amendments. The Secretary shall share the results
15 of such audits with the Secretaries of Health and Human
16 Services and of the Treasury.

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

1 that participants and beneficiaries are protected and af-
2 forded the rights provided under this Act.

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

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

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

11 "(3) TREATMENT LIMITS.—In the case of a
12 group health plan that provides both medical and
13 surgical benefits and mental health or substance-re-
14 lated disorder benefits—

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

1 "(B) TREATMENT LIMIT.—If the plan or
2 coverage includes a treatment limit on substan-
3 tially all medical and surgical benefits in any
4 category of items or services, the plan or cov-
5 erage may not impose such a treatment limit on
6 mental health or substance-related disorder
7 benefits for items and services within such cat-
8 egory that is more restrictive than the predomi-
9 nant treatment limit that is applicable to med-
10 ical and surgical benefits for items and services
11 within such category.
12 "(C) CATEGORIES OF ITEMS AND SERV-
13 ICES FOR APPLICATION OF TREATMENT LIMITS
14 AND BENEFICIARY FINANCIAL REQUIRE-
15 MENTS.—For purposes of this paragraph and
16 paragraph (4), there shall be the following five
17 categories of items and services for benefits,
18 whether medical and surgical benefits or mental
19 health and substance-related disorder benefits,
20 and all medical and surgical benefits and all
21 mental health and substance related benefits
22 shall be classified into one of the following cat-
23 egories:
24 "(i) INPATIENT, IN-NETWORK.—Items
25 and services not described in clause (v)

1 furnished on an inpatient basis and within
2 a network of providers established or rec-
3 ognized under such plan or coverage.
4 "(ii) INPATIENT, OUT-OF-NETWORK.—
5 Items and services not described in clause
6 (v) furnished on an inpatient basis and
7 outside any network of providers estab-
8 lished or recognized under such plan or
9 coverage.
10 "(iii) OUTPATIENT, IN-NETWORK.—
11 Items and services not described in clause
12 (v) furnished on an outpatient basis and
13 within a network of providers established
14 or recognized under such plan or coverage.
15 "(iv) OUTPATIENT, OUT-OF-NET-
16 WORK.—Items and services not described
17 in clause (v) furnished on an outpatient
18 basis and outside any network of providers
19 established or recognized under such plan
20 or coverage.
21 "(v) EMERGENCY CARE.—Items and
22 services, whether furnished on an inpatient
23 or outpatient basis or within or outside
24 any network of providers, required for the
25 treatment of an emergency medical condi-

1 tion (as defined in section 1867(e) of the
2 Social Security Act, including an emer-
3 gency condition relating to mental health
4 or substance-related disorders).
5 "(D) TREATMENT LIMIT DEFINED.—For
6 purposes of this paragraph, the term 'treatment
7 limit' means, with respect to a plan or coverage,
8 limitation on the frequency of treatment, num-
9 ber of visits or days of coverage, or other simi-
10 lar limit on the duration or scope of treatment
11 under the plan or coverage.
12 "(E) PREDOMINANCE.—For purposes of
13 this subsection, a treatment limit or financial
14 requirement with respect to a category of items
15 and services is considered to be predominant if
16 it is the most common or frequent of such type
17 of limit or requirement with respect to such cat-
18 egory of items and services.
19 "(4) BENEFICIARY FINANCIAL REQUIRE-
20 MENTS.—In the case of a group health plan that
21 provides both medical and surgical benefits and
22 mental health or substance-related disorder bene-
23 fits—
24 "(A) NO BENEFICIARY FINANCIAL RE-
25 QUIREMENT.—If the plan or coverage does not

1 include a beneficiary financial requirement (as
2 defined in subparagraph (C)) on substantially
3 all medical and surgical benefits within a cat-
4 egory of items and services (specified in para-
5 graph (3)(C)), the plan or coverage may not im-
6 pose such a beneficiary financial requirement on
7 mental health or substance-related disorder
8 benefits for items and services within such cat-
9 egory.
10 "(B) BENEFICIARY FINANCIAL REQUIRE-
11 MENT.—
12 "(i) TREATMENT OF DEDUCTIBLES,
13 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
14 NANCIAL REQUIREMENTS.—If the plan or
15 coverage includes a deductible, a limitation
16 on out-of-pocket expenses, or similar bene-
17 ficiary financial requirement that does not
18 apply separately to individual items and
19 services on substantially all medical and
20 surgical benefits within a category of items
21 and services, the plan or coverage shall
22 apply such requirement (or, if there is
23 more than one such requirement for such
24 category of items and services, the pre-
25 dominant requirement for such category)

1 both to medical and surgical benefits with-
2 in such category and to mental health and
3 substance-related disorder benefits within
4 such category and shall not distinguish in
5 the application of such requirement be-
6 tween such medical and surgical benefits
7 and such mental health and substance-re-
8 lated disorder benefits.
9 ''(ii) OTHER FINANCIAL REQUIRE-
10 MENTS.—If the plan or coverage includes a
11 beneficiary financial requirement not de-
12 scribed in clause (i) on substantially all
13 medical and surgical benefits within a cat-
14 egory of items and services, the plan or
15 coverage may not impose such financial re-
16 quirement on mental health or substance-
17 related disorder benefits for items and
18 services within such category in a way that
19 results in greater out-of-pocket expenses to
20 the participant or beneficiary than the pre-
21 dominant beneficiary financial requirement
22 applicable to medical and surgical benefits
23 for items and services within such cat-
24 egory.

1 "(C) BENEFICIARY FINANCIAL REQUIRE-
2 MENT DEFINED.—For purposes of this para-
3 graph, the term 'beneficiary financial require-
4 ment' includes, with respect to a plan or cov-
5 erage, any deductible, coinsurance, co-payment,
6 other cost sharing, and limitation on the total
7 amount that may be paid by a participant or
8 beneficiary with respect to benefits under the
9 plan or coverage, but does not include the appli-
10 cation of any aggregate lifetime limit or annual
11 limit."; and
12 (2) in subsection (b)—
13 (A) by striking "construed—" and all that
14 follows through "(1) as requiring" and insert-
15 ing "construed as requiring";
16 (B) by striking "; or" and inserting a pe-
17 riod; and
18 (C) by striking paragraph (2).
19 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
20 BENEFITS AND REVISION OF DEFINITION.—Such section
21 is further amended—
22 (1) by striking "mental health benefits" each
23 place it appears (other than in any provision amend-
24 ed by paragraph (2)) and inserting "mental health
25 or substance-related disorder benefits",

1 (2) by striking ''mental health benefits'' each
2 place it appears in subsections (a)(1)(B)(i),
3 (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting
4 ''mental health and substance-related disorder bene-
5 fits'', and
6 (3) in subsection (e), by striking paragraph (4)
7 and inserting the following new paragraphs:
8 ''(4) MENTAL HEALTH BENEFITS.—The term
9 'mental health benefits' means benefits with respect
10 to services for mental health conditions, as defined
11 under the terms of the plan and in accordance with
12 applicable law, but does not include substance-re-
13 lated disorder benefits.
14 ''(5) SUBSTANCE-RELATED DISORDER BENE-
15 FITS.—The term 'substance-related disorder bene-
16 fits' means benefits with respect to services for sub-
17 stance-related disorders, as defined under the terms
18 of the plan and in accordance with applicable law.''.
19 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
20 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
21 such section, as amended by subsection (a)(1), is further
22 amended by adding at the end the following new para-
23 graph:
24 ''(5) AVAILABILITY OF PLAN INFORMATION.—
25 The criteria for medical necessity determinations

1 made under the plan with respect to mental health
2 and substance-related disorder benefits (or the
3 health insurance coverage offered in connection with
4 the plan with respect to such benefits) shall be made
5 available by the plan administrator (or the health in-
6 surance issuer offering such coverage) in accordance
7 with regulations to any current or potential partici-
8 pant, beneficiary, or contracting provider upon re-
9 quest. The reason for any denial under the plan (or
10 coverage) of reimbursement or payment for services
11 with respect to mental health and substance-related
12 disorder benefits in the case of any participant or
13 beneficiary shall, on request or as otherwise re-
14 quired, be made available by the plan administrator
15 (or the health insurance issuer offering such cov-
16 erage) to the participant or beneficiary in accord-
17 ance with regulations.''.
18 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
19 section (a) of such section is further amended by adding
20 at the end the following new paragraph:
21 ''(6) MINIMUM SCOPE OF COVERAGE AND EQ-
22 UITY IN OUT-OF-NETWORK BENEFITS.—
23 ''(A) MINIMUM SCOPE OF MENTAL
24 HEALTH AND SUBSTANCE-RELATED DISORDER
25 BENEFITS.—In the case of a group health plan

1 (or health insurance coverage offered in connec-
2 tion with such a plan) that provides any mental
3 health or substance-related disorder benefits,
4 the plan or coverage shall include benefits for
5 any mental health condition or substance-re-
6 lated disorder included in the most recent edi-
7 tion of the Diagnostic and Statistical Manual of
8 Mental Disorders published by the American
9 Psychiatric Association.
10 ‘‘(B) EQUITY IN COVERAGE OF OUT-OF-
11 NETWORK BENEFITS.—
12 ‘‘(i) IN GENERAL.—In the case of a
13 group health plan (or health insurance cov-
14 erage offered in connection with such a
15 plan) that provides both medical and sur-
16 gical benefits and mental health or sub-
17 stance-related disorder benefits, if medical
18 and surgical benefits are provided for sub-
19 stantially all items and services in a cat-
20 egory specified in clause (ii) furnished out-
21 side any network of providers established
22 or recognized under such plan or coverage,
23 the mental health and substance-related
24 disorder benefits shall also be provided for
25 items and services in such category fur-

1 nished outside any network of providers es-
2 tablished or recognized under such plan or
3 coverage in accordance with the require-
4 ments of this section.
5 ‘‘(ii) CATEGORIES OF ITEMS AND
6 SERVICES.—For purposes of clause (i),
7 there shall be the following three categories
8 of items and services for benefits, whether
9 medical and surgical benefits or mental
10 health and substance-related disorder bene-
11 fits, and all medical and surgical benefits
12 and all mental health and substance-re-
13 lated disorder benefits shall be classified
14 into one of the following categories:
15 ‘‘(I) EMERGENCY.—Items and
16 services, whether furnished on an in-
17 patient or outpatient basis, required
18 for the treatment of an emergency
19 medical condition (as defined in sec-
20 tion 1867(e) of the Social Security
21 Act, including an emergency condition
22 relating to mental health or sub-
23 stance-related disorders).

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 to which this paragraph applies;
9 and
10 "(ii) 1 percent in the case of each
11 subsequent plan year.
12 "(C) DETERMINATIONS BY ACTUARIES.—
13 Determinations as to increases in actual costs
14 under a plan (or coverage) for purposes of this
15 subsection shall be made in writing and pre-
16 pared and certified by a qualified and licensed
17 actuary who is a member in good standing of
18 the American Academy of Actuaries. Such de-
19 terminations shall be made available by the
20 plan administrator (or health insurance issuer,
21 as the case may be) 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.—A group health plan
6 under this part shall comply with the notice re-
7 quirement under section 712(c)(2)(E) of the
8 Employee Retirement Income Security Act of
9 1974 with respect to a modification of mental
10 health and substance-related disorder benefits
11 as permitted under this paragraph as if such
12 section applied to such plan.
13 "(F) NOTIFICATION OF APPROPRIATE
14 AGENCY.—
15 "(i) IN GENERAL.—A group health
16 plan that, based on a certification de-
17 scribed under subparagraph (C), qualifies
18 for an exemption under this paragraph,
19 and elects to implement the exemption,
20 shall notify the Secretary of Health and
21 Human Services of such election.
22 "(ii) REQUIREMENT.—A notification
23 under clause (i) shall include—
24 "(I) a description of the number
25 of covered lives under the plan (or

1 coverage) involved at the time of the
2 notification, and as applicable, at the
3 time of any prior election of the cost-
4 exemption under this paragraph by
5 such plan (or coverage);
6 "(II) for both the plan year upon
7 which a cost exemption is sought and
8 the year prior, a description of the ac-
9 tual total costs of coverage with re-
10 spect to medical and surgical benefits
11 and mental health and substance-re-
12 lated disorder benefits under the plan;
13 and
14 "(III) for both the plan year
15 upon which a cost exemption is sought
16 and the year prior, the actual total
17 costs of coverage with respect to men-
18 tal health and substance-related dis-
19 order benefits under the plan.
20 "(iii) CONFIDENTIALITY.—A notifica-
21 tion under clause (i) shall be confidential.
22 The Secretary of Health and Human Serv-
23 ices shall make available, upon request to
24 the appropriate committees of Congress
25 and on not more than an annual basis, an

1 anonymous itemization of such notifica-
2 tions, that includes—
3 ''(I) a breakdown of States by
4 the size and any type of employers
5 submitting such notification; and
6 ''(II) a summary of the data re-
7 ceived under clause (ii).
8 ''(G) CONSTRUCTION.—Nothing in this
9 paragraph shall be construed as preventing a
10 group health plan (or health insurance coverage
11 offered in connection with such a plan) from
12 complying with the provisions of this section
13 notwithstanding that the plan or coverage is not
14 required to comply with such provisions due to
15 the application of subparagraph (A).''.
16 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
17 ERS.—Subsection (c)(1)(B) of such section is amended—
18 (1) by inserting ''(or 1 in the case of an em-
19 ployer residing in a State that permits small groups
20 to include a single individual)'' after ''at least 2'' the
21 first place it appears; and
22 (2) by striking ''and who employs at least 2 em-
23 ployees on the first day of the plan year''.
24 (g) ELIMINATION OF SUNSET PROVISION.—Such sec-
25 tion is amended by striking out subsection (f).

1 (h) CLARIFICATION REGARDING PREEMPTION.—
2 Such section is further amended by inserting after sub-
3 section (e) the following new subsection:
4 ''(f) PREEMPTION, RELATION TO STATE LAWS.—
5 ''(1) IN GENERAL.—Nothing in this section
6 shall be construed to preempt any State law that
7 provides greater consumer protections, benefits,
8 methods of access to benefits, rights or remedies
9 that are greater than the protections, benefits, meth-
10 ods of access to benefits, rights or remedies provided
11 under this section.
12 ''(2) CONSTRUCTION.—Nothing in this section
13 shall be construed to affect or modify the provisions
14 of section 2723 with respect to group health plans.''.
15 (i) CONFORMING AMENDMENT TO HEADING.—The
16 heading of such section is amended to read as follows:
17 **"SEC. 2705. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**
18 **RELATED DISORDER BENEFITS.".**
19 (j) EFFECTIVE DATE.—
20 (1) IN GENERAL.—Except as otherwise pro-
21 vided in this subsection, the amendments made by
22 this section shall apply with respect to plan years be-
23 ginning on or after January 1, 2009.

1 (2) ELIMINATION OF SUNSET.—The amend-
2 ment made by subsection (g) shall apply to benefits
3 for services furnished after December 31, 2007.
4 (3) SPECIAL RULE FOR COLLECTIVE BAR-
5 GAINING AGREEMENTS.—In the case of a group
6 health plan maintained pursuant to one or more col-
7 lective bargaining agreements between employee rep-
8 resentatives and one or more employers ratified be-
9 fore the date of the enactment of this Act, the
10 amendments made by this section shall not apply to
11 plan years beginning before the later of—
12 (A) the date on which the last of the col-
13 lective bargaining agreements relating to the
14 plan terminates (determined without regard to
15 any extension thereof agreed to after the date
16 of the enactment of this Act), or
17 (B) January 1, 2009.
18 For purposes of subparagraph (A), any plan amend-
19 ment made pursuant to a collective bargaining
20 agreement relating to the plan which amends the
21 plan solely to conform to any requirement added by
22 this section shall not be treated as a termination of
23 such collective bargaining agreement.

1 **SEC. 4. AMENDMENTS TO THE INTERNAL REVENUE CODE**
2 **OF 1986.**
3 (a) EXTENSION OF PARITY TO TREATMENT LIMITS
4 AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section
5 9812 of the Internal Revenue Code of 1986 is amended—
6 (1) in subsection (a), by adding at the end the
7 following new paragraphs:
8 "(3) TREATMENT LIMITS.—In the case of a
9 group health plan that provides both medical and
10 surgical benefits and mental health or substance-re-
11 lated disorder benefits—
12 "(A) NO TREATMENT LIMIT.—If the plan
13 does not include a treatment limit (as defined
14 in subparagraph (D)) on substantially all med-
15 ical and surgical benefits in any category of
16 items or services (specified in subparagraph
17 (C)), the plan may not impose any treatment
18 limit on mental health or substance-related dis-
19 order benefits that are classified in the same
20 category of items or services.
21 "(B) TREATMENT LIMIT.—If the plan in-
22 cludes a treatment limit on substantially all
23 medical and surgical benefits in any category of
24 items or services, the plan may not impose such
25 a treatment limit on mental health or sub-
26 stance-related disorder benefits for items and

1 services within such category that is more re-
2 strictive than the predominant treatment limit
3 that is applicable to medical and surgical bene-
4 fits for items and 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 five
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 not described in clause (v)
19 furnished on an inpatient basis and within
20 a network of providers established or rec-
21 ognized under such plan.

22 "(ii) INPATIENT, OUT-OF-NETWORK.—
23 Items and services not described in clause
24 (v) furnished on an inpatient basis and

1 outside any network of providers estab-
2 lished or recognized under such plan.
3 "(iii) OUTPATIENT, IN-NETWORK.—
4 Items and services not described in clause
5 (v) furnished on an outpatient basis and
6 within a network of providers established
7 or recognized under such plan.
8 "(iv) OUTPATIENT, OUT-OF-NET-
9 WORK.—Items and services not described
10 in clause (v) furnished on an outpatient
11 basis and outside any network of providers
12 established or recognized under such plan.
13 "(v) EMERGENCY CARE.—Items and
14 services, whether furnished on an inpatient
15 or outpatient basis or within or outside
16 any network of providers, required for the
17 treatment of an emergency medical condi-
18 tion (as defined in section 1867(e) of the
19 Social Security Act, including an emer-
20 gency condition relating to mental health
21 or substance-related disorders).
22 "(D) TREATMENT LIMIT DEFINED.—For
23 purposes of this paragraph, the term 'treatment
24 limit' means, with respect to a plan, limitation
25 on the frequency of treatment, number of visits

1 or days of coverage, or other similar limit on
2 the duration or scope of treatment under the
3 plan.
4 "(E) PREDOMINANCE.—For purposes of
5 this subsection, a treatment limit or financial
6 requirement with respect to a category of items
7 and services is considered to be predominant if
8 it is the most common or frequent of such type
9 of limit or requirement with respect to such cat-
10 egory of items and services.
11 "(4) BENEFICIARY FINANCIAL REQUIRE-
12 MENTS.—In the case of a group health plan that
13 provides both medical and surgical benefits and
14 mental health or substance-related disorder bene-
15 fits—
16 "(A) NO BENEFICIARY FINANCIAL RE-
17 QUIREMENT.—If the plan does not include a
18 beneficiary financial requirement (as defined in
19 subparagraph (C)) on substantially all medical
20 and surgical benefits within a category of items
21 and services (specified in paragraph (3)(C)),
22 the plan may not impose such a beneficiary fi-
23 nancial requirement on mental health or sub-
24 stance-related disorder benefits for items and
25 services within such category.

1 "(B) BENEFICIARY FINANCIAL REQUIRE-
2 MENT.—
3 "(i) TREATMENT OF DEDUCTIBLES,
4 OUT-OF-POCKET LIMITS, AND SIMILAR FI-
5 NANCIAL REQUIREMENTS.—If the plan in-
6 cludes a deductible, a limitation on out-of-
7 pocket expenses, or similar beneficiary fi-
8 nancial requirement that does not apply
9 separately to individual items and services
10 on substantially all medical and surgical
11 benefits within a category of items and
12 services, the plan shall apply such require-
13 ment (or, if there is more than one such
14 requirement for such category of items and
15 services, the predominant requirement for
16 such category) both to medical and sur-
17 gical benefits within such category and to
18 mental health and substance-related dis-
19 order benefits within such category and
20 shall not distinguish in the application of
21 such requirement between such medical
22 and surgical benefits and such mental
23 health and substance-related disorder bene-
24 fits.

1 "(ii) OTHER FINANCIAL REQUIRE-
2 MENTS.—If the plan includes a beneficiary
3 financial requirement not described in
4 clause (i) on substantially all medical and
5 surgical benefits within a category of items
6 and services, the plan may not impose such
7 financial requirement on mental health or
8 substance-related disorder benefits for
9 items and services within such category in
10 a way that results in greater out-of-pocket
11 expenses to the participant or beneficiary
12 than the predominant beneficiary financial
13 requirement applicable to medical and sur-
14 gical benefits for items and services within
15 such category.
16 "(C) BENEFICIARY FINANCIAL REQUIRE-
17 MENT DEFINED.—For purposes of this para-
18 graph, the term 'beneficiary financial require-
19 ment' includes, with respect to a plan, any de-
20 ductible, coinsurance, co-payment, other cost
21 sharing, and limitation on the total amount
22 that may be paid by a participant or beneficiary
23 with respect to benefits under the plan, but
24 does not include the application of any aggre-
25 gate lifetime limit or annual limit.", and

1 (2) in subsection (b)—
2 (A) by striking "construed—" and all that
3 follows through "(1) as requiring" and insert-
4 ing "construed as requiring",
5 (B) by striking "; or" and inserting a pe-
6 riod, and
7 (C) by striking paragraph (2).
8 (b) EXPANSION TO SUBSTANCE-RELATED DISORDER
9 BENEFITS AND REVISION OF DEFINITION.—Section 9812
10 of such Code is further amended—
11 (1) by striking "mental health benefits" each
12 place it appears (other than in any provision amend-
13 ed by paragraph (2)) and inserting "mental health
14 or substance-related disorder benefits",
15 (2) by striking "mental health benefits" each
16 place it appears in subsections (a)(1)(B)(i),
17 (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting
18 "mental health and substance-related disorder bene-
19 fits", and
20 (3) in subsection (e), by striking paragraph (4)
21 and inserting the following new paragraphs:
22 "(4) MENTAL HEALTH BENEFITS.—The term
23 'mental health benefits' means benefits with respect
24 to services for mental health conditions, as defined
25 under the terms of the plan and in accordance with

1 applicable law, but does not include substance-re-
2 lated disorder benefits.

3 "(5) SUBSTANCE-RELATED DISORDER BENE-
4 FITS.—The term 'substance-related disorder bene-
5 fits' means benefits with respect to services for sub-
6 stance-related disorders, as defined under the terms
7 of the plan and in accordance with applicable law.".

8 (c) AVAILABILITY OF PLAN INFORMATION ABOUT
9 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of
10 section 9812 of such Code, as amended by subsection
11 (a)(1), is further amended by adding at the end the fol-
12 lowing new paragraph:

13 "(5) AVAILABILITY OF PLAN INFORMATION.—
14 The criteria for medical necessity determinations
15 made under the plan with respect to mental health
16 and substance-related disorder benefits shall be
17 made available by the plan administrator in accord-
18 ance with regulations to any current or potential
19 participant, beneficiary, or contracting provider upon
20 request. The reason for any denial under the plan of
21 reimbursement or payment for services with respect
22 to mental health and substance-related disorder ben-
23 efits in the case of any participant or beneficiary
24 shall, on request or as otherwise required, be made

1 available by the plan administrator to the partici-
2 pant or beneficiary in accordance with regulations.''.
3 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
4 section (a) of section 9812 of such Code is further amend-
5 ed by adding at the end the following new paragraph:
6 ''(6) MINIMUM SCOPE OF COVERAGE AND EQ-
7 UITY IN OUT-OF-NETWORK BENEFITS.—
8 ''(A) MINIMUM SCOPE OF MENTAL
9 HEALTH AND SUBSTANCE-RELATED DISORDER
10 BENEFITS.—In the case of a group health plan
11 that provides any mental health or substance-
12 related disorder benefits, the plan shall include
13 benefits for any mental health condition or sub-
14 stance-related disorder included in the most re-
15 cent edition of the Diagnostic and Statistical
16 Manual of Mental Disorders published by the
17 American Psychiatric Association.
18 ''(B) EQUITY IN COVERAGE OF OUT-OF-
19 NETWORK BENEFITS.—
20 ''(i) IN GENERAL.—In the case of a
21 group health plan that provides both med-
22 ical and surgical benefits and mental
23 health or substance-related disorder bene-
24 fits, if medical and surgical benefits are
25 provided for substantially all items and

1 services in a category specified in clause
2 (ii) furnished outside any network of pro-
3 viders established or recognized under such
4 plan, the mental health and substance-re-
5 lated disorder benefits shall also be pro-
6 vided for items and services in such cat-
7 egory furnished outside any network of
8 providers established or recognized under
9 such plan in accordance with the require-
10 ments of this section.

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

21 "(I) EMERGENCY.—Items and
22 services, whether furnished on an in-
23 patient or outpatient basis, required
24 for the treatment of an emergency
25 medical condition (as defined in sec-

1 tion 1867(e) of the Social Security
2 Act, including an emergency condition
3 relating to mental health or sub-
4 stance-related disorders).
5 "(II) INPATIENT.—Items and
6 services not described in subclause (I)
7 furnished on an inpatient basis.
8 "(III) OUTPATIENT.—Items and
9 services not described in subclause (I)
10 furnished on an outpatient basis.".
11 (e) REVISION OF INCREASED COST EXEMPTION.—
12 Paragraph (2) of section 9812(c) of such Code is amended
13 to read as follows:
14 "(2) INCREASED COST EXEMPTION.—
15 "(A) IN GENERAL.—With respect to a
16 group health plan, if the application of this sec-
17 tion to such plan results in an increase for the
18 plan year involved of the actual total costs of
19 coverage with respect to medical and surgical
20 benefits and mental health and substance-re-
21 lated disorder benefits under the plan (as deter-
22 mined and certified under subparagraph (C)) by
23 an amount that exceeds the applicable percent-
24 age described in subparagraph (B) of the actual
25 total plan costs, the provisions of this section

1 shall not apply to such plan during the fol-
2 lowing plan year, and such exemption shall
3 apply to the plan for 1 plan year.
4 "(B) APPLICABLE PERCENTAGE.—With re-
5 spect to a plan, the applicable percentage de-
6 scribed in this paragraph shall be—
7 "(i) 2 percent in the case of the first
8 plan year to which this paragraph applies,
9 and
10 "(ii) 1 percent in the case of each
11 subsequent plan year.
12 "(C) DETERMINATIONS BY ACTUARIES.—
13 Determinations as to increases in actual costs
14 under a plan for purposes of this subsection
15 shall be made in writing and prepared and cer-
16 tified by a qualified and licensed actuary who is
17 a member in good standing of the American
18 Academy of Actuaries. Such determinations
19 shall be made available by the plan adminis-
20 trator to the general public.
21 "(D) 6-MONTH DETERMINATIONS.—If a
22 group health plan seeks an exemption under
23 this paragraph, determinations under subpara-
24 graph (A) shall be made after such plan has

1 complied with this section for the first 6
2 months of the plan year involved.
3 "(E) NOTIFICATION OF APPROPRIATE
4 AGENCY.—
5 "(i) IN GENERAL.—A group health
6 plan that, based on a certification de-
7 scribed under subparagraph (C), qualifies
8 for an exemption under this paragraph,
9 and elects to implement the exemption,
10 shall notify the Secretary of the Treasury
11 of such election.
12 "(ii) REQUIREMENT.—A notification
13 under clause (i) shall include—
14 "(I) a description of the number
15 of covered lives under the plan (or
16 coverage) involved at the time of the
17 notification, and as applicable, at the
18 time of any prior election of the cost-
19 exemption under this paragraph by
20 such plan (or coverage);
21 "(II) for both the plan year upon
22 which a cost exemption is sought and
23 the year prior, a description of the ac-
24 tual total costs of coverage with re-
25 spect to medical and surgical benefits

1 and mental health and substance-re-
2 lated disorder benefits under the plan;
3 and
4 "(III) for both the plan year
5 upon which a cost exemption is sought
6 and the year prior, the actual total
7 costs of coverage with respect to men-
8 tal health and substance-related dis-
9 order benefits under the plan.
10 "(iii) CONFIDENTIALITY.—A notifica-
11 tion under clause (i) shall be confidential.
12 The Secretary of the Treasury shall make
13 available, upon request to the appropriate
14 committees of Congress and on not more
15 than an annual basis, an anonymous
16 itemization of such notifications, that in-
17 cludes—
18 "(I) a breakdown of States by
19 the size and any type of employers
20 submitting such notification; and
21 "(II) a summary of the data re-
22 ceived under clause (ii).
23 "(F) CONSTRUCTION.—Nothing in this
24 paragraph shall be construed as preventing a
25 group health plan from complying with the pro-

1 visions of this section notwithstanding that the
2 plan is not required to comply with such provi-
3 sions due to the application of subparagraph
4 (A).''.
5 (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-
6 ERS.—Paragraph (1) of section 9812(c) of such Code is
7 amended to read as follows:
8 ''(1) SMALL EMPLOYER EXEMPTION.—
9 ''(A) IN GENERAL.—This section shall not
10 apply to any group health plan for any plan
11 year of a small employer.
12 ''(B) SMALL EMPLOYER.—For purposes of
13 subparagraph (A), the term 'small employer'
14 means, with respect to a calendar year and a
15 plan year, an employer who employed an aver-
16 age of at least 2 (or 1 in the case of an em-
17 ployer residing in a State that permits small
18 groups to include a single individual) but not
19 more than 50 employees on business days dur-
20 ing the preceding calendar year. For purposes
21 of the preceding sentence, all persons treated as
22 a single employer under subsection (b), (c),
23 (m), or (o) of section 414 shall be treated as 1
24 employer and rules similar to rules of subpara-

1 graphs (B) and (C) of section 4980D(d)(2)
2 shall apply.''.
3 (g) ELIMINATION OF SUNSET PROVISION.—Section
4 9812 of such Code is amended by striking subsection (f).
5 (h) CONFORMING AMENDMENTS TO HEADING.—
6 (1) IN GENERAL.—The heading of section 9812
7 of such Code is amended to read as follows:

8 **''SEC. 9812. EQUITY IN MENTAL HEALTH AND SUBSTANCE-**
9 **RELATED DISORDER BENEFITS.''.**

10 (2) CLERICAL AMENDMENT.—The table of sec-
11 tions for subchapter B of chapter 100 of such Code
12 is amended by striking the item relating to section
13 9812 and inserting the following new item:

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

14 (i) EFFECTIVE DATE.—
15 (1) IN GENERAL.—Except as otherwise pro-
16 vided in this subsection, the amendments made by
17 this section shall apply with respect to plan years be-
18 ginning on or after January 1, 2009.
19 (2) ELIMINATION OF SUNSET.—The amend-
20 ment made by subsection (g) shall apply to benefits
21 for services furnished after December 31, 2007.
22 (3) SPECIAL RULE FOR COLLECTIVE BAR-
23 GAINING AGREEMENTS.—In the case of a group
24 health plan maintained pursuant to one or more col-
25 lective bargaining agreements between employee rep-

1 resentatives and one or more employers ratified be-
2 fore the date of the enactment of this Act, the
3 amendments made by this section (other than sub-
4 section (g)) shall not apply to plan years beginning
5 before the later of—
6 (A) the date on which the last of the col-
7 lective bargaining agreements relating to the
8 plan terminates (determined without regard to
9 any extension thereof agreed to after the date
10 of the enactment of this Act), or
11 (B) January 1, 2009.
12 For purposes of subparagraph (A), any plan amend-
13 ment made pursuant to a collective bargaining
14 agreement relating to the plan which amends the
15 plan solely to conform to any requirement added by
16 this section shall not be treated as a termination of
17 such collective bargaining agreement.

18 **SEC. 5. MEDICAID DRUG REBATE.**

19 Paragraph (1)(B)(i) of section 1927(c) of the Social
20 Security Act (42 U.S.C. 1396r–8(c)) is amended—
21 (1) by striking ''and'' at the end of subclause
22 (IV);
23 (2) in subclause (V)—

1 (A) by inserting "and before January 1,
2 2009, and after December 31, 2014," after
3 "December 31, 1995,"; and
4 (B) by striking the period at the end and
5 inserting "; and"; and
6 (3) by adding at the end the following new sub-
7 clause:
8 "(VI) after December 31, 2008,
9 and before January 1, 2015, is 20.1
10 percent.".
11 **SEC. 6. LIMITATION ON MEDICARE EXCEPTION TO THE**
12 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
13 **FERRALS FOR HOSPITALS.**
14 (a) IN GENERAL.—Section 1877 of the Social Secu-
15 rity Act (42 U.S.C. 1395nn) is amended—
16 (1) in subsection (d)(2)—
17 (A) in subparagraph (A), by striking
18 "and" at the end;
19 (B) in subparagraph (B), by striking the
20 period at the end and inserting "; and"; and
21 (C) by adding at the end the following new
22 subparagraph:
23 "(C) in the case where the entity is a hos-
24 pital, the hospital meets the requirements of
25 paragraph (3)(D).";

1 (2) in subsection (d)(3)—
2 (A) in subparagraph (B), by striking
3 "and" at the end;
4 (B) in subparagraph (C), by striking the
5 period at the end and inserting "; and"; and
6 (C) by adding at the end the following new
7 subparagraph:
8 "(D) the hospital meets the requirements
9 described in subsection (i)(1) not later than 18
10 months after the date of the enactment of this
11 subparagraph."; and
12 (3) by adding at the end the following new sub-
13 section:
14 "(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY
15 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-
16 MENT PROHIBITION.—
17 "(1) REQUIREMENTS DESCRIBED.—For pur-
18 poses of subsection (d)(3)(D), the requirements de-
19 scribed in this paragraph for a hospital are as fol-
20 lows:
21 "(A) PROVIDER AGREEMENT.—The hos-
22 pital had—
23 "(i) physician ownership on the date
24 of enactment of this subsection; and

1 “(ii) a provider agreement under section 1866 in effect on such date of enactment.

4 “(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

11 “(C) PREVENTING CONFLICTS OF INTEREST.—

13 “(i) The hospital submits to the Secretary an annual report containing a detailed description of—

16 “(I) the identity of each physician owner and any other owners of the hospital; and

19 “(II) the nature and extent of all ownership interests in the hospital.

21 “(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision re-

1 garding the receipt of care, as determined
2 by the Secretary—
3 ''(I) the ownership interest of
4 such referring physician in the hos-
5 pital; and
6 ''(II) if applicable, any such own-
7 ership interest of the treating physi-
8 cian.
9 ''(iii) The hospital does not condition
10 any physician ownership interests either di-
11 rectly or indirectly on the physician owner
12 making or influencing referrals to the hos-
13 pital or otherwise generating business for
14 the hospital.
15 ''(iv) The hospital discloses the fact
16 that the hospital is partially owned by phy-
17 sicians—
18 ''(I) on any public website for the
19 hospital; and
20 ''(II) in any public advertising
21 for the hospital.
22 ''(D) ENSURING BONA FIDE INVEST-
23 MENT.—
24 ''(i) Physician owners in the aggregate
25 do not own more than 40 percent of the

1 total value of the investment interests held
2 in the hospital or in an entity whose assets
3 include the hospital.
4 ''(ii) The investment interest of any
5 individual physician owner does not exceed
6 2 percent of the total value of the invest-
7 ment interests held in the hospital or in an
8 entity whose assets include the hospital.
9 ''(iii) Any ownership or investment in-
10 terests that the hospital offers to a physi-
11 cian owner are not offered on more favor-
12 able terms than the terms offered to a per-
13 son who is not a physician owner.
14 ''(iv) The hospital (or any investors in
15 the hospital) does not directly or indirectly
16 provide loans or financing for any physi-
17 cian owner investments in the hospital.
18 ''(v) The hospital (or any investors in
19 the hospital) does not directly or indirectly
20 guarantee a loan, make a payment toward
21 a loan, or otherwise subsidize a loan, for
22 any individual physician owner or group of
23 physician owners that is related to acquir-
24 ing any ownership interest in the hospital.

1 "(vi) Investment returns are distrib-
2 uted to each investor in the hospital in an
3 amount that is directly proportional to the
4 investment of capital by such investor in
5 the hospital.
6 "(vii) Physician owners do not receive,
7 directly or indirectly, any guaranteed re-
8 ceipt of or right to purchase other business
9 interests related to the hospital, including
10 the purchase or lease of any property
11 under the control of other investors in the
12 hospital or located near the premises of the
13 hospital.
14 "(viii) The hospital does not offer a
15 physician owner the opportunity to pur-
16 chase or lease any property under the con-
17 trol of the hospital or any other investor in
18 the hospital on more favorable terms than
19 the terms offered to an individual who is
20 not a physician owner.
21 "(E) PATIENT SAFETY.—
22 "(i) Insofar as the hospital admits a
23 patient and does not have any physician
24 available on the premises to provide serv-
25 ices during all hours in which the hospital

1 is providing services to such patient, before
2 admitting the patient—
3 "(I) the hospital discloses such
4 fact to a patient; and
5 "(II) following such disclosure,
6 the hospital receives from the patient
7 a signed acknowledgment that the pa-
8 tient understands such fact.
9 "(ii) The hospital has the capacity
10 to—
11 "(I) provide assessment and ini-
12 tial treatment for patients; and
13 "(II) refer and transfer patients
14 to hospitals with the capability to
15 treat the needs of the patient in-
16 volved.
17 "(2) PUBLICATION OF INFORMATION RE-
18 PORTED.—The Secretary shall publish, and update
19 on an annual basis, the information submitted by
20 hospitals under paragraph (1)(C)(i) on the public
21 Internet website of the Centers for Medicare & Med-
22 icaid Services.
23 "(3) EXCEPTION TO PROHIBITION ON EXPAN-
24 SION OF FACILITY CAPACITY.—
25 "(A) PROCESS.—

1 "(i) ESTABLISHMENT.—The Secretary
2 shall establish and implement a process
3 under which an applicable hospital (as de-
4 fined in subparagraph (E)) may apply for
5 an exception from the requirement under
6 paragraph (1)(B).
7 "(ii) OPPORTUNITY FOR COMMUNITY
8 INPUT.—The process under clause (i) shall
9 provide individuals and entities in the com-
10 munity that the applicable hospital apply-
11 ing for an exception is located with the op-
12 portunity to provide input with respect to
13 the application.
14 "(iii) TIMING FOR IMPLEMENTA-
15 TION.—The Secretary shall implement the
16 process under clause (i) on the date that is
17 18 months after the date of enactment of
18 this subsection.
19 "(iv) REGULATIONS.—Not later than
20 the date that is 18 months after the date
21 of enactment of this subsection, the Sec-
22 retary shall promulgate regulations to
23 carry out the process under clause (i).
24 "(B) FREQUENCY.—The process described
25 in subparagraph (A) shall permit an applicable

1 hospital to apply for an exception up to once
2 every 2 years.
3 "(C) PERMITTED INCREASE.—
4 "(i) IN GENERAL.—Subject to clause
5 (ii) and subparagraph (D), an applicable
6 hospital granted an exception under the
7 process described in subparagraph (A) may
8 increase the number of operating rooms
9 and beds of the applicable hospital above
10 the baseline number of operating rooms
11 and beds of the applicable hospital (or, if
12 the applicable hospital has been granted a
13 previous exception under this paragraph,
14 above the number of operating rooms and
15 beds of the hospital after the application of
16 the most recent increase under such an ex-
17 ception) by an amount determined appro-
18 priate by the Secretary.
19 "(ii) LIFETIME 50 PERCENT INCREASE
20 LIMITATION.—The Secretary shall not per-
21 mit an increase in the number of operating
22 rooms and beds of an applicable hospital
23 under clause (i) to the extent such increase
24 would result in the number of operating
25 rooms and beds of the applicable hospital

1 exceeding 150 percent of the baseline num-
2 ber of operating rooms and beds of the ap-
3 plicable hospital.
4 "(iii) BASELINE NUMBER OF OPER-
5 ATING ROOMS AND BEDS.—In this para-
6 graph, the term 'baseline number of oper-
7 ating rooms and beds' means the number
8 of operating rooms and beds of the appli-
9 cable hospital as of the date of enactment
10 of this subsection.
11 "(D) INCREASE LIMITED TO FACILITIES
12 ON THE MAIN CAMPUS OF THE HOSPITAL.—
13 Any increase in the number of operating rooms
14 and beds of an applicable hospital pursuant to
15 this paragraph may only occur in facilities on
16 the main campus of the applicable hospital.
17 "(E) APPLICABLE HOSPITAL.—In this
18 paragraph, the term 'applicable hospital' means
19 a hospital—
20 "(i) that is located in a county in
21 which the percentage increase in the popu-
22 lation during the most recent 5-year period
23 (as of the date of the application under
24 subparagraph (A)) is at least 200 percent
25 of the percentage increase in the popu-

1 lation growth of the United States during
2 that period, as estimated by Bureau of the
3 Census;
4 "(ii) whose annual percent of total in-
5 patient admissions and outpatient visits
6 that represent inpatient admissions and
7 outpatient visits under the program under
8 title XIX is equal to or greater than the
9 average percent with respect to such ad-
10 missions and visits for all hospitals located
11 in the State;
12 "(iii) that does not discriminate
13 against beneficiaries of Federal health care
14 programs and does not permit physicians
15 practicing at the hospital to discriminate
16 against such beneficiaries;
17 "(iv) that is located in a State in
18 which the average bed capacity in the
19 State is less than the national average bed
20 capacity; and
21 "(v) in the case of a hospital lo-
22 cated—
23 "(I) in a core-based statistical
24 area, that is located in such an area
25 in which the average bed occupancy

1 rate in such area is greater than 80
2 percent; or
3 "(II) outside of a core-based sta-
4 tistical area, that is located in a State
5 in which the average bed occupancy
6 rate is greater than 80 percent.
7 "(F) PUBLICATION OF FINAL DECI-
8 SIONS.—The Secretary shall publish final deci-
9 sions with respect to applications under this
10 paragraph in the Federal Register.
11 "(G) LIMITATION ON REVIEW.—There
12 shall be no administrative or judicial review
13 under section 1869, section 1878, or otherwise
14 of the process under this paragraph (including
15 the establishment of such process).
16 "(4) COLLECTION OF OWNERSHIP AND INVEST-
17 MENT INFORMATION.—For purposes of clauses (i)
18 and (ii) of paragraph (1)(D), the Secretary shall col-
19 lect physician ownership and investment information
20 for each hospital as it existed on the date of the en-
21 actment of this subsection.
22 "(5) PHYSICIAN OWNER DEFINED.—For pur-
23 poses of this subsection, the term 'physician owner'
24 means a physician (or an immediate family member

1 of such physician) with a direct or an indirect own-
2 ership interest in the hospital.''.
3 (b) ENFORCEMENT.—
4 (1) ENSURING COMPLIANCE.—The Secretary of
5 Health and Human Services shall establish policies
6 and procedures to ensure compliance with the re-
7 quirements described in subsection (i)(1) of section
8 1877 of the Social Security Act, as added by sub-
9 section (a)(3), beginning on the date such require-
10 ments first apply. Such policies and procedures may
11 include unannounced site reviews of hospitals.
12 (2) AUDITS.—Beginning not later than 18
13 months after the date of the enactment of this Act,
14 the Secretary of Health and Human Services shall
15 conduct audits to determine if hospitals violate the
16 requirements referred to in paragraph (1).
17 (c) ADJUSTMENT TO PAQI FUND.—Section
18 1848(l)(2)(A)(i)(III) of the Social Security Act (42 U.S.C.
19 1395w-4(l)(2)(A)(i)(III)), as amended by section
20 101(a)(2) of the Medicare, Medicaid, and SCHIP Exten-
21 sion Act of 2007 (Public Law 110-173), is amended by
22 striking ''$4,960,000,000'' and inserting
23 ''$5,120,000,000''.
24 **SEC. 7. STUDIES AND REPORTS.**
25 (a) IMPLEMENTATION OF ACT.—

1 (1) GAO STUDY.—The Comptroller General of
2 the United States shall conduct a study that evalu-
3 ates the effect of the implementation of the amend-
4 ments made by this Act on—
5 (A) the cost of health insurance coverage;
6 (B) access to health insurance coverage
7 (including the availability of in-network pro-
8 viders);
9 (C) the quality of health care;
10 (D) Medicare, Medicaid, and State and
11 local mental health and substance abuse treat-
12 ment spending;
13 (E) the number of individuals with private
14 insurance who received publicly funded health
15 care for mental health and substance-related
16 disorders;
17 (F) spending on public services, such as
18 the criminal justice system, special education,
19 and income assistance programs;
20 (G) the use of medical management of
21 mental health and substance-related disorder
22 benefits and medical necessity determinations
23 by group health plans (and health insurance
24 issuers offering health insurance coverage in
25 connection with such plans) and timely access

1 by participants and beneficiaries to clinically-in-
2 dicated care for mental health and substance-
3 use disorders; and
4 (H) other matters as determined appro-
5 priate by the Comptroller General.
6 (2) REPORT.—Not later than 2 years after the
7 date of enactment of this Act, the Comptroller Gen-
8 eral shall prepare and submit to the appropriate
9 committees of the Congress a report containing the
10 results of the study conducted under paragraph (1).
11 (b) GAO REPORT ON UNIFORM PATIENT PLACE-
12 MENT CRITERIA.—Not later than 18 months after the
13 date of the enactment of this Act, the Comptroller General
14 shall submit to each House of the Congress a report on
15 availability of uniform patient placement criteria for men-
16 tal health and substance-related disorders that could be
17 used by group health plans and health insurance issuers
18 to guide determinations of medical necessity and the ex-
19 tent to which health plans utilize such criteria. If such
20 criteria do not exist, the report shall include recommenda-
21 tions on a process for developing such criteria.
22 (c) DOL BIANNUAL REPORT ON ANY OBSTACLES IN
23 OBTAINING COVERAGE.—Every two years, the Secretary
24 of Labor, in consultation with the Secretaries of Health
25 and Human Services and the Treasury, shall submit to

1 the appropriate committees of each House of the Congress
2 a report on obstacles, if any, that individuals face in ob-
3 taining mental health and substance-related disorder care
4 under their health plans.