

**SUBSTITUTE AMENDMENT TO THE AMENDMENT IN  
THE NATURE OF A SUBSTITUTE TO H.R.1424  
OFFERED BY MR. KLINE OF MINNESOTA**

Strike all after the enacting clause and insert the following:

1 **SECTION 1. SHORT TITLE.**

2       This Act may be cited as the “Mental Health Parity  
3 Act of 2007”.

4 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**  
5 **COME SECURITY ACT OF 1974.**

6       (a) MENTAL HEALTH PARITY.—

7           (1) IN GENERAL.—Subpart B of part 7 of title  
8 I of the Employee Retirement Income Security Act  
9 of 1974 is amended by inserting after section 712  
10 (29 U.S.C. 1185a) the following:

11 **“SEC. 712A. MENTAL HEALTH PARITY.**

12       “(a) IN GENERAL.—In the case of a group health  
13 plan (or health insurance coverage offered in connection  
14 with such a plan) that provides both medical and surgical  
15 benefits and mental health benefits, such plan or coverage  
16 shall ensure that—

17           “(1) the financial requirements applicable to  
18 such mental health benefits are no more restrictive

1 than the financial requirements applied to substan-  
2 tially all medical and surgical benefits covered by the  
3 plan (or coverage), including deductibles, copay-  
4 ments, coinsurance, out-of-pocket expenses, and an-  
5 nual and lifetime limits, except that the plan (or cov-  
6 erage) may not establish separate cost sharing re-  
7 quirements that are applicable only with respect to  
8 mental health benefits; and

9 “(2) the treatment limitations applicable to  
10 such mental health benefits are no more restrictive  
11 than the treatment limitations applied to substan-  
12 tially all medical and surgical benefits covered by the  
13 plan (or coverage), including limits on the frequency  
14 of treatment, number of visits, days of coverage, or  
15 other similar limits on the scope or duration of  
16 treatment.

17 “(b) CLARIFICATIONS.—In the case of a group health  
18 plan (or health insurance coverage offered in connection  
19 with such a plan) that provides both medical and surgical  
20 benefits and mental health benefits, and complies with the  
21 requirements of subsection (a), such plan or coverage shall  
22 not be prohibited from—

23 “(1) negotiating separate reimbursement or  
24 provider payment rates and service delivery systems  
25 for different benefits consistent with subsection (a);

1           “(2) managing the provision of mental health  
2           benefits in order to provide medically necessary serv-  
3           ices for covered benefits, including through the use  
4           of any utilization review, authorization or manage-  
5           ment practices, the application of medical necessity  
6           and appropriateness criteria applicable to behavioral  
7           health, and the contracting with and use of a net-  
8           work of providers; and

9           “(3) applying the provisions of this section in a  
10          manner that takes into consideration similar treat-  
11          ment settings or similar treatments.

12          “(c) IN- AND OUT-OF-NETWORK.—In the case of a  
13          group health plan (or health insurance coverage offered  
14          in connection with such a plan) that provides both medical  
15          and surgical benefits and mental health benefits, and that  
16          provides such benefits on both an in- and out-of-network  
17          basis pursuant to the terms of the plan (or coverage), such  
18          plan (or coverage) shall ensure that the requirements of  
19          this section are applied to both in- and out-of-network  
20          services by comparing in-network medical and surgical  
21          benefits to in-network mental health benefits and out-of-  
22          network medical and surgical benefits to out-of-network  
23          mental health benefits.

24          “(d) SMALL EMPLOYER EXEMPTION.—

1           “(1) IN GENERAL.—Except as provided in para-  
2           graph (2), this section shall not apply to any group  
3           health plan (or group health insurance coverage of-  
4           fered in connection with a group health plan) for  
5           any plan year of any employer who employed an av-  
6           erage of at least 2 (or 1 in the case of an employer  
7           residing in a State that permits small groups to in-  
8           clude a single individual) but not more than 50 em-  
9           ployees on business days during the preceding cal-  
10          endar year.

11          “(2) NO PREEMPTION OF CERTAIN STATE  
12          LAWS.—Nothing in paragraph (1) shall be construed  
13          to preempt any State insurance law relating to em-  
14          ployers in the State who employed an average of at  
15          least 2 (or 1 in the case of an employer residing in  
16          a State that permits small groups to include a single  
17          individual) but not more than 50 employees on busi-  
18          ness days during the preceding calendar year.

19          “(3) APPLICATION OF CERTAIN RULES IN DE-  
20          TERMINATION OF EMPLOYER SIZE.—For purposes of  
21          this subsection:

22                 “(A) APPLICATION OF AGGREGATION RULE  
23                 FOR EMPLOYERS.—Rules similar to the rules  
24                 under subsections (b), (c), (m), and (o) of sec-  
25                 tion 414 of the Internal Revenue Code of 1986

1 shall apply for purposes of treating persons as  
2 a single employer.

3 “(B) EMPLOYERS NOT IN EXISTENCE IN  
4 PRECEDING YEAR.—In the case of an employer  
5 which was not in existence throughout the pre-  
6 ceding calendar year, the determination of  
7 whether such employer is a small employer shall  
8 be based on the average number of employees  
9 that it is reasonably expected such employer  
10 will employ on business days in the current cal-  
11 endar year.

12 “(C) PREDECESSORS.—Any reference in  
13 this paragraph to an employer shall include a  
14 reference to any predecessor of such employer.

15 “(e) COST EXEMPTION.—

16 “(1) IN GENERAL.—With respect to a group  
17 health plan (or health insurance coverage offered in  
18 connections with such a plan), if the application of  
19 this section to such plan (or coverage) results in an  
20 increase for the plan year involved of the actual total  
21 costs of coverage with respect to medical and sur-  
22 gical benefits and mental health benefits under the  
23 plan (as determined and certified under paragraph  
24 (3)) by an amount that exceeds the applicable per-  
25 centage described in paragraph (2) of the actual

1 total plan costs, the provisions of this section shall  
2 not apply to such plan (or coverage) during the fol-  
3 lowing plan year, and such exemption shall apply to  
4 the plan (or coverage) for 1 plan year. An employer  
5 may elect to continue to apply mental health parity  
6 pursuant to this section with respect to the group  
7 health plan (or coverage) involved regardless of any  
8 increase in total costs.

9 “(2) APPLICABLE PERCENTAGE.—With respect  
10 to a plan (or coverage), the applicable percentage de-  
11 scribed in this paragraph shall be—

12 “(A) 2 percent in the case of the first plan  
13 year in which this section is applied; and

14 “(B) 1 percent in the case of each subse-  
15 quent plan year.

16 “(3) DETERMINATIONS BY ACTUARIES.—Deter-  
17 minations as to increases in actual costs under a  
18 plan (or coverage) for purposes of this section shall  
19 be made and certified by a qualified and licensed ac-  
20 tuary who is a member in good standing of the  
21 American Academy of Actuaries.

22 “(4) 6-MONTH DETERMINATIONS.—If a group  
23 health plan (or a health insurance issuer offering  
24 coverage in connection with a group health plan)  
25 seeks an exemption under this subsection, deter-

1       minations under paragraph (1) shall be made after  
2       such plan (or coverage) has complied with this sec-  
3       tion for the first 6 months of the plan year involved.

4               “(5) NOTIFICATION.—An election to modify  
5       coverage of mental health benefits as permitted  
6       under this subsection shall be treated as a material  
7       modification in the terms of the plan as described in  
8       section 102(a) and shall be subject to the applicable  
9       notice requirements under section 104(b)(1).

10              “(6) NOTIFICATION TO APPROPRIATE AGEN-  
11       CY.—

12                      “(A) IN GENERAL.—A group health plan  
13       (or a health insurance issuer offering coverage  
14       in connection with a group health plan) that,  
15       based upon a certification described under para-  
16       graph (3), qualifies for an exemption under this  
17       subsection, and elects to implement the exemp-  
18       tion, shall notify the Department of Labor or  
19       the Department of Health and Human Services,  
20       as appropriate, of such election.

21                      “(B) REQUIREMENT.—A notification  
22       under subparagraph (A) shall include—

23                              “(i) a description of the number of  
24                              covered lives under the plan (or coverage)  
25                              involved at the time of the notification, and

1 as applicable, at the time of any prior elec-  
2 tion of the cost-exemption under this sub-  
3 section by such plan (or coverage);

4 “(ii) for both the plan year upon  
5 which a cost exemption is sought and the  
6 year prior, a description of the actual total  
7 costs of coverage with respect to medical  
8 and surgical benefits and mental health  
9 benefits under the plan; and

10 “(iii) for both the plan year upon  
11 which a cost exemption is sought and the  
12 year prior, the actual total costs of cov-  
13 erage with respect to mental health bene-  
14 fits under the plan.

15 “(C) CONFIDENTIALITY.—A notification  
16 under subparagraph (A) shall be confidential.  
17 The Department of Labor and the Department  
18 of Health and Human Services shall make  
19 available, upon request and on not more than  
20 an annual basis, an anonymous itemization of  
21 such notifications, that includes—

22 “(i) a breakdown of States by the size  
23 and type of employers submitting such no-  
24 tification; and

1                   “(ii) a summary of the data received  
2                   under subparagraph (B).

3           “(f) MENTAL HEALTH BENEFITS.—In this section,  
4 the term ‘mental health benefits’ means benefits with re-  
5 spect to mental health services (including substance use  
6 disorder treatment) as defined under the terms of the  
7 group health plan or coverage, and when applicable as may  
8 be defined under State law when applicable to health in-  
9 surance coverage offered in connection with a group health  
10 plan.”.

11           (2) CONFORMING AMENDMENT.—The table of  
12 contents in section 1 of such Act is amended by in-  
13 sserting after the item relating to section 714 the fol-  
14 lowing new item:

“Sec. 712A. Mental health parity.”.

15           (b) EFFECTIVE DATE.—

16           (1) IN GENERAL.—The provisions of this sec-  
17 tion (and the amendments made thereby) shall apply  
18 to group health plans (or health insurance coverage  
19 offered in connection with such plans) beginning in  
20 the first plan year that begins on or after January  
21 1 of the first calendar year that begins more than  
22 1 year after the date of the enactment of this Act.

23           (2) TERMINATION OF CERTAIN PROVISIONS.—  
24 Section 712 of the Employee Retirement Income Se-

1 curity Act of 1974 (29 U.S.C. 1185a) is amended by  
2 striking subsection (f) and inserting the following:

3 “(f) SUNSET.—This section shall not apply to bene-  
4 fits for services furnished after the effective date described  
5 in section 2(b)(1) of the Mental Health Parity Act of  
6 2007.”.

7 (c) SPECIAL ERISA PREEMPTION RULE.—

8 (1) IN GENERAL.—Section 731 of the Employee  
9 Retirement Income Security Act of 1974 (29 U.S.C.  
10 1191) is amended—

11 (A) by redesignating subsections (e) and  
12 (d) as subsections (e) and (f), respectively; and

13 (B) by inserting after subsection (b), the  
14 following:

15 “(c) SPECIAL RULE IN CASE OF MENTAL HEALTH  
16 PARITY REQUIREMENTS.—

17 “(1) IN GENERAL.—Notwithstanding any provi-  
18 sion of section 514 to the contrary, the provisions of  
19 this part relating to a group health plan or a health  
20 insurance issuer offering coverage in connection with  
21 a group health plan shall supersede any provision of  
22 State law that establishes, implements, or continues  
23 in effect any mental health parity standard or re-  
24 quirement which differs from the mental health par-

1       ity standards or requirements as defined in sub-  
2       sections (a), (c), or (e) of section 712A.

3               “(2) CLARIFICATIONS.—

4                       “(A) IN GENERAL.—To the extent that  
5                       any provision of State law is preempted under  
6                       this subsection, any remaining provision of such  
7                       State law shall remain in effect and shall not  
8                       be preempted.

9                       “(B) RULE OF CONSTRUCTION RELATING  
10                      TO CERTAIN STATE LAWS.—Nothing in this  
11                      subsection shall be construed to preempt State  
12                      insurance laws relating to the individual insur-  
13                      ance market or to small employers (as such  
14                      term is defined for purposes of section  
15                      712A(d)).

16                      “(C) RULE OF CONSTRUCTION RELATING  
17                      TO MENTAL HEALTH AND OUT-OF-NETWORK  
18                      COVERAGE.—Consistent with subsections (a),  
19                      (c), and (e) of section 712A, nothing in section  
20                      712A shall be construed to require a group  
21                      health plan (or coverage offered in connection  
22                      with such a plan) to provide the following:

23                               “(i) Any mental health benefits, ex-  
24                               cept that State insurance laws applicable  
25                               to health insurance coverage that require

1 coverage of specific items, benefits, or serv-  
2 ices (including for specific mental health  
3 conditions) are specifically not preempted  
4 by this subsection or such section 712A.

5 “(ii) Out-of-network coverage for ei-  
6 ther medical and surgical benefits or men-  
7 tal health benefits, except that State insur-  
8 ance laws applicable to health insurance  
9 coverage relating to the provision of out-of-  
10 network mental health coverage are specifi-  
11 cally not preempted by this subsection or  
12 such section 712A.”.

13 (2) EFFECTIVE DATE.—The provisions of this  
14 subsection shall take effect with respect to a State  
15 on the date on which the provisions of subsection (a)  
16 apply with respect to group health plans and health  
17 insurance coverage offered in connection with group  
18 health plans.

19 (d) FEDERAL ADMINISTRATIVE RESPONSIBIL-  
20 ITIES.—

21 (1) GROUP HEALTH PLAN OMBUDSMAN.—The  
22 Secretary of Labor shall designate an individual  
23 within the Department of Labor to serve as the  
24 group health plan ombudsman for the Department.  
25 Such ombudsman shall serve as an initial point of

1 contact to permit individuals to obtain information  
2 and provide assistance concerning coverage of men-  
3 tal health services under group health plans in ac-  
4 cordance with this section.

5 (2) AUDITS.—The Secretary of Labor shall pro-  
6 vide for the conduct of random audits of group  
7 health plans (and health insurance coverage offered  
8 in connection with such plans) to ensure that such  
9 plans are in compliance with this section (and the  
10 amendments made by this section).

11 (3) GOVERNMENT ACCOUNTABILITY OFFICE  
12 STUDY.—

13 (A) STUDY.—The Comptroller General  
14 shall conduct a study that evaluates the effect  
15 of the implementation of the amendments made  
16 by this section on the cost of health insurance  
17 coverage, access to health insurance coverage  
18 (including the availability of in-network pro-  
19 viders), the quality of health care, the impact  
20 on benefits and coverage for mental health and  
21 substance use disorders, the impact of any addi-  
22 tional cost or savings to the plan, the impact on  
23 out-of-network coverage for mental health bene-  
24 fits (including substance use disorder treat-  
25 ment), the impact on State mental health ben-

1           efit mandate laws, other impact on the business  
2           community and the Federal Government, and  
3           other issues as determined appropriate by the  
4           Comptroller General.

5           (B) REPORT.—Not later than 2 years after  
6           the date of enactment of this Act, the Comp-  
7           troller General shall prepare and submit to the  
8           appropriate committees of Congress a report  
9           containing the results of the study conducted  
10          under subparagraph (A).

11          (4) REGULATIONS.—Not later than 1 year after  
12          the date of enactment of this Act, the Secretary of  
13          Labor shall promulgate final regulations to carry out  
14          this section.

15 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

16                   **ACT RELATING TO THE GROUP MARKET.**

17          (a) EXTENSION OF PARITY TO TREATMENT LIMITS  
18          AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section  
19          2705 of the Public Health Service Act (42 U.S.C. 300gg–  
20          5) is amended—

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

23                          “(3) TREATMENT LIMITS.—

24                                  “(A) NO TREATMENT LIMIT.—If the plan  
25                                  or coverage does not include a treatment limit

1 (as defined in subparagraph (D)) on substan-  
2 tially all medical and surgical benefits in any  
3 category of items or services (specified in sub-  
4 paragraph (C)), the plan or coverage may not  
5 impose any treatment limit on mental health  
6 and substance-related disorder benefits that are  
7 classified in the same category of items or serv-  
8 ices.

9 “(B) TREATMENT LIMIT.—If the plan or  
10 coverage includes a treatment limit on substan-  
11 tially all medical and surgical benefits in any  
12 category of items or services, the plan or cov-  
13 erage may not impose such a treatment limit on  
14 mental health and substance-related disorder  
15 benefits for items and services within such cat-  
16 egory that are more restrictive than the pre-  
17 dominant treatment limit that is applicable to  
18 medical and surgical benefits for items and  
19 services within such category.

20 “(C) CATEGORIES OF ITEMS AND SERV-  
21 ICES FOR APPLICATION OF TREATMENT LIMITS  
22 AND BENEFICIARY FINANCIAL REQUIRE-  
23 MENTS.—For purposes of this paragraph and  
24 paragraph (4), there shall be the following four  
25 categories of items and services for benefits,

1           whether medical and surgical benefits or mental  
2           health and substance-related disorder benefits,  
3           and all medical and surgical benefits and all  
4           mental health and substance related benefits  
5           shall be classified into one of the following cat-  
6           egories:

7                   “(i) INPATIENT, IN-NETWORK.—Items  
8                   and services furnished on an inpatient  
9                   basis and within a network of providers es-  
10                  tablished or recognized under such plan or  
11                  coverage.

12                  “(ii) INPATIENT, OUT-OF-NETWORK.—  
13                  Items and services furnished on an inpa-  
14                  tient basis and outside any network of pro-  
15                  viders established or recognized under such  
16                  plan or coverage.

17                  “(iii) OUTPATIENT, IN-NETWORK.—  
18                  Items and services furnished on an out-  
19                  patient basis and within a network of pro-  
20                  viders established or recognized under such  
21                  plan or coverage.

22                  “(iv) OUTPATIENT, OUT-OF-NET-  
23                  WORK.—Items and services furnished on  
24                  an outpatient basis and outside any net-

1 work of providers established or recognized  
2 under such plan or coverage.

3 “(D) TREATMENT LIMIT DEFINED.—For  
4 purposes of this paragraph, the term ‘treatment  
5 limit’ means, with respect to a plan or coverage,  
6 limitation on the frequency of treatment, num-  
7 ber of visits or days of coverage, or other simi-  
8 lar limit on the duration or scope of treatment  
9 under the plan or coverage.

10 “(E) PREDOMINANCE.—For purposes of  
11 this subsection, a treatment limit or financial  
12 requirement with respect to a category of items  
13 and services is considered to be predominant if  
14 it is the most common or frequent of such type  
15 of limit or requirement with respect to such cat-  
16 egory of items and services.

17 “(4) BENEFICIARY FINANCIAL REQUIRE-  
18 MENTS.—

19 “(A) NO BENEFICIARY FINANCIAL RE-  
20 QUIREMENT.—If the plan or coverage does not  
21 include a beneficiary financial requirement (as  
22 defined in subparagraph (C)) on substantially  
23 all medical and surgical benefits within a cat-  
24 egory of items and services (specified in para-  
25 graph (3)(C)), the plan or coverage may not im-

1           pose such a beneficiary financial requirement on  
2           mental health and substance-related disorder  
3           benefits for items and services within such cat-  
4           egory.

5           “(B) BENEFICIARY FINANCIAL REQUIRE-  
6           MENT.—

7                   “(i) TREATMENT OF DEDUCTIBLES,  
8                   OUT-OF-POCKET LIMITS, AND SIMILAR FI-  
9                   NANCIAL REQUIREMENTS.—If the plan or  
10                  coverage includes a deductible, a limitation  
11                  on out-of-pocket expenses, or similar bene-  
12                  ficiary financial requirement that does not  
13                  apply separately to individual items and  
14                  services on substantially all medical and  
15                  surgical benefits within a category of items  
16                  and services, the plan or coverage shall  
17                  apply such requirement (or, if there is  
18                  more than one such requirement for such  
19                  category of items and services, the pre-  
20                  dominant requirement for such category)  
21                  both to medical and surgical benefits with-  
22                  in such category and to mental health and  
23                  substance-related disorder benefits within  
24                  such category and shall not distinguish in  
25                  the application of such requirement be-

1           tween such medical and surgical benefits  
2           and such mental health and substance-re-  
3           lated disorder benefits.

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

19          “(C) BENEFICIARY FINANCIAL REQUIRE-  
20          MENT DEFINED.—For purposes of this para-  
21          graph, the term ‘beneficiary financial require-  
22          ment’ includes, with respect to a plan or cov-  
23          erage, any deductible, coinsurance, co-payment,  
24          other cost sharing, and limitation on the total  
25          amount that may be paid by a participant or

1 beneficiary with respect to benefits under the  
2 plan or coverage, but does not include the appli-  
3 cation of any aggregate lifetime limit or annual  
4 limit.”; and

5 (2) in subsection (b)—

6 (A) by striking “construed—” and all that  
7 follows through “(1) as requiring” and insert-  
8 ing “construed as requiring”;

9 (B) by striking “; or” and inserting a pe-  
10 riod; and

11 (C) by striking paragraph (2).

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

15 (1) by striking “mental health benefits” and in-  
16 serting “mental health and substance-related dis-  
17 order benefits” each place it appears; and

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

19 (A) by striking “MENTAL HEALTH BENE-  
20 FITS” and inserting “MENTAL HEALTH AND  
21 SUBSTANCE-RELATED DISORDER BENEFITS”;

22 (B) by striking “benefits with respect to  
23 mental health services” and inserting “benefits  
24 with respect to services for mental health condi-  
25 tions or substance-related disorders”; and

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

4 (c) AVAILABILITY OF PLAN INFORMATION ABOUT  
5 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of  
6 such section, as amended by subsection (a)(1), is further  
7 amended by adding at the end the following new para-  
8 graph:

9 “(5) AVAILABILITY OF PLAN INFORMATION.—  
10 The criteria for medical necessity determinations  
11 made under the plan with respect to mental health  
12 and substance-related disorder benefits (or the  
13 health insurance coverage offered in connection with  
14 the plan with respect to such benefits) shall be made  
15 available by the plan administrator (or the health in-  
16 surance issuer offering such coverage) to any cur-  
17 rent or potential participant, beneficiary, or con-  
18 tracting provider upon request. The reason for any  
19 denial under the plan (or coverage) of reimburse-  
20 ment or payment for services with respect to mental  
21 health and substance-related disorder benefits in the  
22 case of any participant or beneficiary shall, upon re-  
23 quest, be made available by the plan administrator  
24 (or the health insurance issuer offering such cov-  
25 erage) to the participant or beneficiary.”.

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

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

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

20 “(B) EQUITY IN COVERAGE OF OUT-OF-  
21 NETWORK BENEFITS.—

22 “(i) IN GENERAL.—In the case of a  
23 plan or coverage that provides both med-  
24 ical and surgical benefits and mental  
25 health and substance-related disorder bene-

1 fits, if medical and surgical benefits are  
2 provided for substantially all items and  
3 services in a category specified in clause  
4 (ii) furnished outside any network of pro-  
5 viders established or recognized under such  
6 plan or coverage, the mental health and  
7 substance-related disorder benefits shall  
8 also be provided for items and services in  
9 such category furnished outside any net-  
10 work of providers established or recognized  
11 under such plan or coverage in accordance  
12 with the requirements of this section.

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

23 “(I) EMERGENCY.—Items and  
24 services, whether furnished on an in-  
25 patient or outpatient basis, required

1 for the treatment of an emergency  
2 medical condition (including an emer-  
3 gency condition relating to mental  
4 health and substance-related dis-  
5 orders).

6 “(II) INPATIENT.—Items and  
7 services not described in subclause (I)  
8 furnished on an inpatient basis.

9 “(III) OUTPATIENT.—Items and  
10 services not described in subclause (I)  
11 furnished on an outpatient basis.”.

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

15 “(2) INCREASED COST EXEMPTION.—

16 “(A) IN GENERAL.—With respect to a  
17 group health plan (or health insurance coverage  
18 offered in connection with such a plan), if the  
19 application of this section to such plan (or cov-  
20 erage) results in an increase for the plan year  
21 involved of the actual total costs of coverage  
22 with respect to medical and surgical benefits  
23 and mental health and substance-related dis-  
24 order benefits under the plan (as determined  
25 and certified under subparagraph (C)) by an

1 amount that exceeds the applicable percentage  
2 described in subparagraph (B) of the actual  
3 total plan costs, the provisions of this section  
4 shall not apply to such plan (or coverage) dur-  
5 ing the following plan year, and such exemption  
6 shall apply to the plan (or coverage) for 1 plan  
7 year.

8 “(B) APPLICABLE PERCENTAGE.—With re-  
9 spect to a plan (or coverage), the applicable  
10 percentage described in this paragraph shall  
11 be—

12 “(i) 2 percent in the case of the first  
13 plan year which begins after the date of  
14 the enactment of the Paul Wellstone Men-  
15 tal Health and Addiction Equity Act of  
16 2007; and

17 “(ii) 1 percent in the case of each  
18 subsequent plan year.

19 “(C) DETERMINATIONS BY ACTUARIES.—  
20 Determinations as to increases in actual costs  
21 under a plan (or coverage) for purposes of this  
22 subsection shall be made by a qualified actuary  
23 who is a member in good standing of the Amer-  
24 ican Academy of Actuaries. Such determina-

1           tions shall be certified by the actuary and be  
2           made available to the general public.

3           “(D) 6-MONTH DETERMINATIONS.—If a  
4           group health plan (or a health insurance issuer  
5           offering coverage in connection with such a  
6           plan) seeks an exemption under this paragraph,  
7           determinations under subparagraph (A) shall be  
8           made after such plan (or coverage) has com-  
9           plied with this section for the first 6 months of  
10          the plan year involved.

11          “(E) NOTIFICATION.—A group health plan  
12          under this part shall comply with the notice re-  
13          quirement under section 712(c)(2)(E) of the  
14          Employee Retirement Income Security Act of  
15          1974 with respect to the a modification of men-  
16          tal health and substance-related disorder bene-  
17          fits as permitted under this paragraph as if  
18          such section applied to such plan.”.

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

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

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

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

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

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

9           “(1) IN GENERAL.—Nothing in this section  
10           shall be construed to preempt any State law that  
11           provides greater consumer protections, benefits,  
12           methods of access to benefits, rights or remedies  
13           that are greater than the protections, benefits, meth-  
14           ods of access to benefits, rights or remedies provided  
15           under this section.

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

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

21           **“SEC. 2705.”.**

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

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.—

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

18 “(B) TREATMENT LIMIT.—If the plan in-  
19 cludes a treatment limit on substantially all  
20 medical and surgical benefits in any category of  
21 items or services, the plan may not impose such  
22 a treatment limit on mental health and sub-  
23 stance-related disorder benefits for items and  
24 services within such category that are more re-  
25 strictive than the predominant treatment limit

1 that is applicable to medical and surgical bene-  
2 fits for items and services 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 four  
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 furnished on an inpatient  
17 basis and within a network of providers es-  
18 tablished or recognized under such plan or  
19 coverage.

20 “(ii) INPATIENT, OUT-OF-NETWORK.—  
21 Items and services furnished on an inpa-  
22 tient basis and outside any network of pro-  
23 viders established or recognized under such  
24 plan or coverage.

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

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

11                  “(D) TREATMENT LIMIT DEFINED.—For  
12                  purposes of this paragraph, the term ‘treatment  
13                  limit’ means, with respect to a plan, limitation  
14                  on the frequency of treatment, number of visits  
15                  or days of coverage, or other similar limit on  
16                  the duration or scope of treatment under the  
17                  plan.

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

1           “(4) BENEFICIARY FINANCIAL REQUIRE-  
2           MENTS.—

3           “(A) NO BENEFICIARY FINANCIAL RE-  
4           QUIREMENT.—If the plan does not include a  
5           beneficiary financial requirement (as defined in  
6           subparagraph (C)) on substantially all medical  
7           and surgical benefits within a category of items  
8           and services (specified in paragraph (3)(C)),  
9           the plan may not impose such a beneficiary fi-  
10          nancial requirement on mental health and sub-  
11          stance-related disorder benefits for items and  
12          services within such category.

13          “(B) BENEFICIARY FINANCIAL REQUIRE-  
14          MENT.—

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

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

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

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, any de-  
5           ductible, coinsurance, co-payment, other cost  
6           sharing, and limitation on the total amount  
7           that may be paid by a participant or beneficiary  
8           with respect to benefits under the plan, but  
9           does not include the application of any aggre-  
10          gate lifetime limit or annual limit.”; and

11          (2) in subsection (b)—

12                 (A) by striking “construed—” and all that  
13                 follows through “(1) as requiring” and insert-  
14                 ing “construed as requiring”;

15                 (B) by striking “; or” and inserting a pe-  
16                 riod; and

17                 (C) by striking paragraph (2).

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

21                 (1) by striking “mental health benefits” and in-  
22                 serting “mental health and substance-related dis-  
23                 order benefits” each place it appears; and

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

1 (A) by striking “MENTAL HEALTH BENE-  
2 FITS” in the heading and inserting “MENTAL  
3 HEALTH AND SUBSTANCE-RELATED DISORDER  
4 BENEFITS”;

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

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

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

17 “(5) AVAILABILITY OF PLAN INFORMATION.—  
18 The criteria for medical necessity determinations  
19 made under the plan with respect to mental health  
20 and substance-related disorder benefits shall be  
21 made available by the plan administrator to any cur-  
22 rent or potential participant, beneficiary, or con-  
23 tracting provider upon request. The reason for any  
24 denial under the plan of reimbursement or payment  
25 for services with respect to mental health and sub-

1       stance-related disorder benefits in the case of any  
2       participant or beneficiary shall, upon request, be  
3       made available by the plan administrator to the par-  
4       ticipant or beneficiary.”.

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

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

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

24               “(B) EQUITY IN COVERAGE OF OUT-OF-  
25       NETWORK BENEFITS.—

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

17           “(ii) CATEGORIES OF ITEMS AND  
18           SERVICES.—For purposes of clause (i),  
19           there shall be the following three categories  
20           of items and services for benefits, whether  
21           medical and surgical benefits or mental  
22           health and substance-related disorder bene-  
23           fits, and all medical and surgical benefits  
24           and all mental health and substance-re-

1           lated disorder benefits shall be classified  
2           into one of the following categories:

3                   “(I) EMERGENCY.—Items and  
4                   services, whether furnished on an in-  
5                   patient or outpatient basis, required  
6                   for the treatment of an emergency  
7                   medical condition (including an emer-  
8                   gency condition relating to mental  
9                   health and substance-related dis-  
10                  orders).

11                   “(II) INPATIENT.—Items and  
12                   services not described in subclause (I)  
13                   furnished on an inpatient basis.

14                   “(III) OUTPATIENT.—Items and  
15                   services not described in subclause (I)  
16                   furnished on an outpatient basis.”.

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

20                   “(2) INCREASED COST EXEMPTION.—

21                   “(A) IN GENERAL.—With respect to a  
22                   group health plan, if the application of this sec-  
23                   tion to such plan results in an increase for the  
24                   plan year involved of the actual total costs of  
25                   coverage with respect to medical and surgical

1 benefits and mental health and substance-re-  
2 lated disorder benefits under the plan (as deter-  
3 mined and certified under subparagraph (C)) by  
4 an amount that exceeds the applicable percent-  
5 age described in subparagraph (B) of the actual  
6 total plan costs, the provisions of this section  
7 shall not apply to such plan during the fol-  
8 lowing plan year, and such exemption shall  
9 apply to the plan for 1 plan year.

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

13 “(i) 2 percent in the case of the first  
14 plan year which begins after the date of  
15 the enactment of the Paul Wellstone Men-  
16 tal Health and Addiction Equity Act of  
17 2007; and

18 “(ii) 1 percent in the case of each  
19 subsequent plan year.

20 “(C) DETERMINATIONS BY ACTUARIES.—  
21 Determinations as to increases in actual costs  
22 under a plan for purposes of this subsection  
23 shall be made by a qualified actuary who is a  
24 member in good standing of the American  
25 Academy of Actuaries. Such determinations

1 shall be certified by the actuary and be made  
2 available to the general public.

3 “(D) 6-MONTH DETERMINATIONS.—If a  
4 group health plan seeks an exemption under  
5 this paragraph, determinations under subpara-  
6 graph (A) shall be made after such plan has  
7 complied with this section for the first 6  
8 months of the plan year involved.”.

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

12 “(1) SMALL EMPLOYER EXEMPTION.—

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

16 “(B) SMALL EMPLOYER.—For purposes of  
17 subparagraph (A), the term ‘small employer’  
18 means, with respect to a calendar year and a  
19 plan year, an employer who employed an aver-  
20 age of at least 2 (or 1 in the case of an em-  
21 ployer residing in a State that permits small  
22 groups to include a single individual) but not  
23 more than 50 employees on business days dur-  
24 ing the preceding calendar year. For purposes  
25 of the preceding sentence, all persons treated as

1 a single employer under subsection (b), (c),  
2 (m), or (o) of section 414 shall be treated as 1  
3 employer and rules similar to rules of subpara-  
4 graphs (B) and (C) of section 4980D(d)(2)  
5 shall apply.”.

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

8 (h) CONFORMING AMENDMENTS TO HEADING.—

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

11 **“SEC. 9812.”.**

12 (2) CLERICAL AMENDMENT.—The table of sec-  
13 tions for subchapter B of chapter 100 of the Inter-  
14 nal Revenue Code of 1986 is amended by striking  
15 the item relating to section 9812 and inserting the  
16 following new item:

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

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