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MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001

SEPTEMBER 6, 2001.—Ordered to be printed

Mr. KENNEDY, from the Committee on Health, Education, Labor,
and Pensions, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany S. 543]

The Committee on Health, Education, Labor, and Pensions, to which was referred the bill (S. 543) to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

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I. PURPOSE AND SUMMARY

The purpose of S. 543 “The Mental Health Equitable Treatment Act of 2001” is to expand the Mental Health Parity Act (MHPA) of 1996 to ensure full parity in the coverage of mental health benefits

by prohibiting certain group health plan (or health insurance coverage offered in connection with a group plan) from imposing treatment limitations or financial requirements on benefits for mental illnesses unless comparable limitations are imposed on medical and surgical benefits.

Mental illnesses are defined as all categories of mental health conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR). Benefits are defined under the terms and conditions of the plan and coverage is contingent on the mental health treatment being included in an authorized treatment plan that is in accordance with standard protocols and the treatment must meet the plan's medical necessity criteria. However, the bill does not mandate that health plans offer mental health benefits, nor does it require a plan to cover a specific service, so long as the exclusion does not create disparity. Like the MHPA, S. 543 does not require plans to provide coverage for benefits relating to substance abuse and chemical dependency and there is a small business exemption for companies with 50 or fewer employees. S. 543 is modeled after the mental health benefits provided through the Federal Employees Health Benefits Program.

II. HISTORY OF LEGISLATION

THE MENTAL HEALTH PARITY ACT

Congressional lawmakers first addressed mental health parity during the debate on the Clinton administration's health care reform proposal in the 103rd Congress. The Clinton plan (introduced as S. 1757 and H.R. 3600) initially provided for limited coverage of mental illness, but included a phase-in of full parity by 2001. Both committee reported Senate bills (S. 2296, S. 2351) included provisions for establishing full mental health parity in the context of overall health care reform, as did legislation reported by the House Committee on Education and Labor (H.R. 3600). Attempts to enact comprehensive health care reform ended on the Senate floor in August 1994. The full House did not debate health care reform legislation.

At the beginning of the 104th Congress, Senators Domenici and Wellstone introduced legislation to eliminate the inequities in mental health coverage under private insurance (S. 298). Similar language was approved by the Senate on April 18, 1996, as an amendment to S. 1028, the Health Insurance Reform Act.¹ The amendment was later dropped in conference. A compromise amendment that the sponsors had proposed to the conferees was eventually incorporated as the Mental Health Parity Act in the FY1997 appropriations bill for the Departments of Veterans' Affairs and Housing and Urban Development.²

The MHPA of 1996 amended the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act to establish new federal standards for mental health coverage offered by employer-sponsored group health plans (or health insurance coverage offered in connection with such a plan). The law prohibits plans and issuers from imposing annual and lifetime dollar limits

¹ This legislation was eventually signed into law as the Health Insurance Portability and Accountability Act (HIPAA), P.L. 104-191.

² P.L. 104-204, Title VII, codified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5.

on mental health coverage that are more restrictive than those imposed on medical and surgical coverage. However, the MHPA includes several important limitations. The law only applies to plans that offer mental health benefits, but does not require a plan to include any mental health benefits. Also employers with 50 or fewer employees are exempt from the law. In addition, plan sponsors that can demonstrate that MHPA compliance increased their group-health plan costs by at least 1 percent can apply for an exemption.³ Finally, the law does not require full parity. Group plans that provide mental health coverage may impose more restrictive treatment limitations (e.g., hospital days or inpatient visits) or cost-sharing provisions (e.g., co-payments, deductibles) on their mental health coverage compared to their medical and surgical coverage.

The MHPA applies to most employer-sponsored group health plans, including fully insured and self-insured plans,⁴ but not to the individual (nongroup) health insurance market. Under provisions included in the 1997 Balanced Budget Act (P.L. 105-33), Medicaid managed care plans and State Children's Health Insurance Programs must comply with the requirements of the MHPA.⁵ The law does not apply to Medicare. The MHPA became effective for group health plans for plan years beginning on or after January 1, 1998. The law will sunset on September 30, 2001.

In preparation for the MHPA's sunset and possible reauthorization, the Senate HELP Committee requested the General Accounting Office (GAO) to report on the law's implementation and effects. The GAO presented its findings in testimony before the committee on May 18, 2000 (S. Rept. 106-582). The agency surveyed 863 employers in 26 states without parity laws and concluded that while most employers are in compliance with the MHPA, many of them have adopted other plan design features that are more restrictive for mental health coverage than for medical and surgical coverage.⁶ The GAO found that although 86 percent of the employers reported compliance with the MHPA, a majority of these plans (87 percent) restricted their mental health coverage in other ways. For example, about two-thirds of MHPA-compliant plans covered fewer outpatient visits and hospital days for mental health treatment than for other medical treatment. Despite concerns about the MHPA's effect on claims costs, only 3 percent of employers surveyed by GAO reported that their costs had increased, and less than 1 percent of employers dropped their mental health coverage altogether following the law's enactment.

Notwithstanding its limited provisions, the MHPA was a groundbreaking step forward in the evolution of state mental health policy.

³ Insurers are required to claim exemption only on the basis of actual cost increases. Less than 12 private firms and roughly 5 non-federal public plans have applied for the 1 percent cost exemption in the 1996 law.

⁴ Employers provide group coverage to their employees either by purchasing a group policy from an insurance company (fully insured coverage) or by funding their own health plan and assuming the financial risk (self-insured coverage).

⁵ 42 U.S.C. 1396u-2(b)(8); 42 U.S.C. 1397cc(f)(2).

⁶ U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, GAO/HEHS-00-95, May 10, 2000.

STATE EXPERIENCE

States began to address the inequities in mental health coverage in the 1970s. More than a dozen states enacted laws requiring health plans operating within the state to offer a specific set of mental health benefits. While these mandated-benefit laws increased coverage, they had important limitations. They seldom provided catastrophic coverage against the financial risk of severe mental illness and they did not apply to certain employer-sponsored benefits which are regulated exclusively under federal ERISA law.⁷ Also, State mandated-benefit laws frequently exempted health maintenance organizations (HMOs).

In 1991, Texas and North Carolina became the first states to enact mental health parity legislation. The laws required health insurers that covered State government employees to provide equal coverage for mental and physical conditions. Prior to enactment of the Mental Health Parity Act in 1996, 5 more states passed laws that required state-regulated group plans to provide parity in mental health coverage.

In total 35 states have enacted legislation to establish standards for coverage of mental illness.⁸ A total of 23 states now have laws that mandate full parity [as defined by the Health Policy Tracking Service, i.e., equal benefits for mental illness and other medical conditions in terms of treatment limitations (inpatient stays, outpatient visits) and cost sharing (deductibles, copays, annual & lifetime dollar limits)] for some forms of mental illness.⁹ However, these laws vary both in the type of plan and the mental illnesses to which they apply. In 13 of those states, the full parity laws apply to group and individual insurance, whereas in 6 states the laws apply only to group insurance. In the remaining 4 states, the parity laws apply only to State employee plans. The State parity laws also vary in the types of mental illnesses covered. Although some State laws apply to all the psychiatric conditions included in the DSM IV,¹⁰ a majority of the laws require parity coverage only for a limited set of illnesses that are narrowly designated as “serious” or “biologically based” mental illness.¹¹ Finally, about half of the State laws include a small-employer exemption.

Most of the States that have not passed comprehensive parity laws have enacted more limited mental health legislation for a variety of reasons such as cost and stigma. Some States require that a minimal level of coverage be provided for mental health (i.e., mandated-benefit laws). Others have enacted laws that require an insurer to include certain mental health benefits if that insurer opts to provide mental health coverage. In 3 States, plans that choose to offer mental health coverage must achieve full parity with their medical and surgical coverage.

⁷Last year, the Department of Labor estimated that almost 130 million Americans were enrolled in private employer-sponsored group health plans. Forty-three percent of those enrollees were covered by self-insured plans.

⁸Information on state mental health parity laws is based on data compiled by the National Conference of State Legislatures' Health Policy Tracking Service [<http://www.ncsl.org>].

⁹The 23 states are: AR, CA, CO, CT, DE, HI, IN, ME, MD, MA, MN, MT, NH, NJ, NM, NC, OK, RI, SC, SD, TX, VT, VA.

¹⁰The DSM IV, produced by the American Psychiatric Association, is a comprehensive system of diagnosis for psychiatric conditions. The fourth and current edition was first published in 1994.

¹¹The illnesses included under these definitions vary greatly by State.

THE MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001 (S. 543)

The Mental Health Equitable Treatment Act of 2001 (S. 543) was introduced by Senator Domenici for himself and Senators Wellstone, Specter, Kennedy, Chafee, Dodd, Cochran, Reed, Reid, Warner, Grassley, Roberts, Durbin, and Johnson on March 15, 2001, and referred to the Committee on Health, Education, Labor, and Pensions.

After introduction, a hearing was held on July 11, 2001. The following individuals presented testimony:

The Honorable Paul Wellstone (D-MN)

The Honorable Pete Domenici (R-NM)

Edward Flynn, Associate Director for Retirement and Insurance,
Office of Personnel Management, Washington, DC.

Lisa Cohen, Bordentown, New Jersey

Henry Harbin, M.D., Chairman of the Board and Chief Executive
Officer, Magellan Health Services, Columbia, Maryland

Dr. Darrel A. Regier, M.D. M.P.H., Executive Director, American
Psychiatric Institute for Research and Education, Washington,
DC.

Senators Wellstone and Domenici both urged the committee to pass S. 543 and build on the limited parity requirements in the 1996 law. They described the enormous impact of mental illness on the American population and reminded committee members that there is no scientific justification for the current inequities in health insurance coverage between mental health and other medical conditions. Many mental illnesses have been found to have a biological basis, and available treatments are just as effective as those for other medical conditions. The Senators also affirmed the intent of the law to cover all mental illnesses, and not to restrict the bill to specific diagnoses. The Senators also summarized recent studies showing that under managed behavioral health care, equitable mental health treatment can be provided without escalating costs.

William Flynn reviewed the implementation of mental health parity in the Federal Employees Health Benefits Program (FEHBP), pursuant to President Clinton's June 1999 Executive Order. He reported that parity implementation has resulted in an average premium increase of 1.64 percent for fee-for-service plans and 0.3 percent for HMOs. The Office of Personnel Management and the Department of Health and Human Services are conducting a 3-year evaluation of the FEHBP parity initiative.

Lisa Cohen, who suffers both from bipolar disorder (manic depression) and idiopathic thrombocytopenia (a rare blood disorder) described the inequities in her health insurance coverage for her two medical conditions. While effective treatments exist for both illnesses, her employer-sponsored health plan provides complete coverage only for her blood disease. Coverage of her psychiatric care is subject to higher co-payments, and limits on doctor's visits and hospital stays.

Dr. Harbin, who heads Magellan Health Services, the country's largest managed behavioral healthcare organization (MBHO), explained how MBHOs have minimized the impact of parity implementation on premium costs. Most health plans now subcontract with MBHOs to provide the mental health (and substance abuse)

component of their health insurance benefit package. Magellan, which provides services to approximately 70 million people, has yet to see implementation of State parity laws increase total health care premium costs by more than 1 percent. These modest cost increases apply both to large and small employers, and in rural, urban and suburban areas.

Dr. Regier, who served as the scientific director of the four recent Congressionally-mandated National Advisory Mental Health Council reports on mental health parity, focused on the impact managed behavioral health care has had on controlling the cost of implementing parity. He also emphasized that parity is an important step toward overcoming the stigma associated with mental illness.

Mr. Flynn, Dr. Harbin, and Dr. Regier all stated that where benefits have been mandated, they have been more cost effective.

III. BACKGROUND AND DESCRIPTION

More than 50 million American adults experience a diagnosed mental illness each year, and 5.5 million have a severely debilitating mental illness, such as schizophrenia or bipolar disorder. Approximately 20 percent of those under age 18 have mental disorders that result in functional impairment, with 5 to 9 percent of these children experiencing severe handicaps in their ability to live normal lives.

Advocates for the mentally ill have long fought for legislation mandating parity (i.e., equality) in health insurance coverage of mental and physical illnesses. Mental health advocates argue that there is no scientific justification for discrimination in mental health coverage, which they believe only reinforces the stigma that many in society attach to mental illness. Their efforts to combat discrimination received an important boost with the release of the 1999 Surgeon General's Report on Mental Health. The report reviewed the extensive scientific literature on mental health and concluded that mental health is fundamental to overall health, and that mental disorders are real health conditions that have an immense impact on individuals, families, and communities. The report found that the efficacy of mental health treatments is well documented and a range of effective treatments exists for most mental disorders.¹²

Today private health insurance plans typically provide lower levels of coverage for treating mental illness than for treating other illnesses due to concerns about cost and adverse selection. But the basis for concern has been reduced over time as biomedical research has offered many new advances in the scientific understanding of the causes of mental illnesses and in the development of new treatments that are both efficacious and cost-effective. At the same time, parity legislation has gained support among federal and state lawmakers in light of recent evidence that full parity can be implemented without significant cost increases within the context of managed care. Moreover, as managed behavioral health tools have been refined over time, employers and other purchasers are increasingly moving away from a fee-for-service model towards a managed behavioral health model. Some large employers have

¹²The Surgeon General's Report on Mental Health is available at [<http://www.surgeongeneral.gov>].

been able to offer more generous mental health benefits through the use of managed care without experiencing the added cost associated with expanded benefits. One employer, Delta Airlines, testified before the Committee in 2000 that expanded access to mental health benefits has resulted in lower overall costs, for instance by reducing medical/surgical claims and absenteeism rates. Indeed, this experience is consistent with findings that show that expanded mental health access can be achieved at minimal cost if provided in a managed care setting.

Health benefit plans typically have more restrictive coverage of mental illnesses than physical illnesses. Common ways health plans have restricted coverage of mental illness include: (1) lower annual or lifetime dollar limits;¹³ (2) lower service limits such as the number of covered hospital days or outpatient visits; and (3) higher cost-sharing requirements such as deductibles, co-payments, or coinsurances. As a result of restrictions on coverage, individuals with mental illness often do not obtain adequate treatment, and those receiving treatment can quickly exhaust their benefits.

The MHPA focused on eliminating inequities in annual and lifetime mental health benefits only. The law applies only to group health plans offering mental health benefits, and requires that annual and lifetime dollar limits for mental health coverage be no more restrictive than for other medical and surgical coverage. Exempted from the law's requirements are plans sponsored by an employer with 50 or fewer employees. Group plans that experience a 1 percent or more increase in plan costs as a result of the new law may apply for an exemption. The 1996 law does not require that employers provide mental health benefits or cover treatment for substance abuse and chemical dependency. Further, the law did not address other coverage restrictions, such as cost-sharing or treatment limits. The Act became effective on January 1, 1998 and has a sunset deadline of September 30, 2001.

As of January 2001, all 8.5 million Federal employees have mental health treatment parity in their health benefits. At the White House Conference on mental health in June 1999, President Clinton directed the Federal Office of Personnel Management (OPM) to implement full parity for both mental health and substance abuse benefits in health plans offered under the Federal Employees Health Benefits Program (FEHBP) beginning in 2001. As implemented, parity in the FEHBP means that in-network benefits coverage for mental health, substance abuse, medical, surgical, and hospital services will have the same limitations and cost-sharing requirements (such as deductibles, coinsurance, and copayments). Coverage is provided for all categories of mental health and substance abuse listed in the DSM IV. Treatment plans must be in accordance with standard protocols and meet medically necessity determination criteria.

According to the OPM, parity implementation is expected to result in an average premium increase of 1.64 percent for fee-for-service plans and 0.3 percent for HMOs. Health plans are implementing the parity benefit in a variety of ways. Some plans are using the services of managed behavioral health care organizations, while others are managing their own provider networks. OPM and

¹³The MHPA of 1996 prohibited such restrictions.

the Department of Health and Human Services are conducting a 3-year evaluation of the FEHBP parity initiative.¹⁴ The 2001 Act is modeled after the mental health benefits provided through the FEHBP.

The “Mental Health Equitable Treatment Act of 2001” (S. 543), takes another step toward achieving mental health treatment parity through Federal legislation. While it does not mandate that health plans offer any mental health benefits or coverage for specific mental health services, it does prohibit health plans from placing treatment limits or financial requirements that are lower than those for medical and surgical benefits. The bill defines “treatment limitations” as limits on the frequency of treatment, the number of visits, the number of covered hospital days, or other limits on the scope and duration of treatment. “Financial requirements” are defined to include deductibles, coinsurance, co-payments, and catastrophic maximums. Coverage is contingent on the mental health treatment being included in an authorized treatment plan that is in accordance with standard protocols and the treatment must meet the plan’s medical necessity criteria.

Mental illnesses are defined as all categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV–TR).¹⁵ Like the MHPA, S. 543 does not require plans to provide coverage for benefits relating to substance abuse or chemical dependency and there is a small business exemption for companies with 50 or fewer employees. S. 543 is modeled after the mental health benefits provided through the Federal Employees Health Benefits Program. Parity requirements must be applied separately to each benefit package if more than one package is offered by a plan. Where a plan offers in-network and out-of-network mental health benefits, S. 543 only applies to in-network benefits so long as the plan provides reasonable access to in-network mental health providers and facilities.

IV. COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 22, 2001.

Hon. EDWARD M. KENNEDY,
*Chairman, Committee on Health, Education, Labor, and Pensions,
U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 543, the Mental Health Equitable Treatment Act of 2001.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts for federal costs are Jennifer Bowman and Alexis Ahlstrom. The staff contact for the state and local impact is Leo Lex. The staff contacts for the private-sec-

¹⁴Additional information on FEHBP’s implementation of mental health parity may be found on the OPM’s Web site at [<http://www.opm.gov/insure/health/index.htm>].

¹⁵American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000.

tor impact are Jennifer Bowman, Stuart Hagen, and James Baumgardner.

Sincerely,

DAN L. CRIPPEN, *Director*.

Enclosure.

S. 543—Mental Health Equitable Treatment Act of 2001

Summary: The Mental Health Equitable Treatment Act of 2001 would prohibit group health plans and group health insurance issuers that provide both medical and surgical benefits and mental health benefits from imposing treatment limitations or financial requirements for coverage of mental health benefits that are different from those used for medical and surgical benefits.

The bill would affect the federal budget because it would result in higher premiums for employer-sponsored health benefits. Higher premiums, in turn, would result in more of an employee's compensation being received in the form of nontaxable employer-paid premiums, and less in the form of taxable wages. As a result of this shift, federal income and payroll tax revenues would decline. The Congressional Budget Office (CBO) estimates that the proposal would reduce federal tax revenues by \$230 million in 2002 and by \$5.4 billion over the 2002–2011 period. Because S. 543 would affect receipts, pay-as-you-go procedures would apply to the bill.

S. 543 would preempt state laws that have less stringent requirements for mental health coverage than those in this bill. That preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA). However, because the preemption only would prohibit the application of state regulatory law, CBO estimates that the costs of the mandate would not be significant and thus would not exceed the threshold established by UMRA (\$56 million in 2001, adjusted annually for inflation). As a result of this legislation, some state, local, and tribal governments would pay higher health insurance premiums for their employees. However, these costs would not result from intergovernmental mandates, but would be costs passed on to them by private insurers who would face a private-sector mandate to comply with the requirements of the bill.

The bill would impose a private-sector mandate on group health plans and group health insurance issuers by prohibiting them from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. Under current law, the Mental Health Parity Act of 1996 requires a more limited form of parity between mental health and medical and surgical coverage. That mandate is set to expire at the end of fiscal year 2001. Thus, S. 543 would both extend and expand the existing mandate requiring mental health parity. CBO estimates that the direct costs of the private-sector mandate in the bill would equal about \$3 billion in 2002, and would grow in later years. That amount would significantly exceed the annual threshold established by UMRA (\$113 million in 2001, adjusted for inflation) in each of the years that the mandate would be effective.

Estimated cost to the Federal Government: The estimated budgetary impact of the bill is shown in Table 1.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF S. 543

	By fiscal year, in millions of dollars—										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
CHANGES IN REVENUES											
On-budget	0	-150	-290	-330	-360	-370	-390	-410	-430	-450	-500
Off-budget ¹	0	-70	-140	-160	-170	-180	-190	-200	-210	-220	-230
Total changes	0	-230	-430	-490	-520	-550	-580	-600	-630	-660	-730

¹ Revenues from Social Security payroll taxes are designated as "off-budget."

Basis of estimate: This bill would prohibit group health plans and group health insurance issuers who offer mental health benefits from imposing treatment limitations or financial requirements for mental health benefits that are different from those used for medical and surgical benefits. For plans that offer mental health benefits through a network of mental health providers, the requirement for parity of benefits would apply to those benefits provided by members of the plan's network of health providers, not to benefits provided by health professionals outside of the plan's network. The provision would apply to benefits for any mental health condition listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, but would not apply to benefits for substance abuse treatment. The bill would not require group health plans to offer mental health benefits, but laws in some states require that plans cover those benefits.

The provision would apply to both self-insured and fully insured group health plans. Small employers (those employing between 2 and 50 employees in a year) would be exempt from the bill's requirements, as would individuals purchasing insurance in the individual market. In states with laws that are more stringent than the provisions of S. 543, fully insured group health plans would be required to comply with the state law, while self-insured plans would be required to comply with the provisions of S. 543.

CBO's estimate of the cost of this bill is based in part on published results of a model developed by the Hay Group. That model relies on data from several sources, including the claims experience of private health insurers participating in the Federal Employees Health Benefits (FEHB) program and the Medical Expenditure Panel Survey. CBO adjusted those results to account for the current and future use of managed care arrangements for providing mental health benefits and the increased use of prescription drugs that mental health parity would be likely to induce. Also, CBO took account of the effects of existing state and federal rules that place requirements similar to those in the bill on certain entities. (For example, the Office of Personnel Management implemented mental health and substance abuse parity in the FEHB program in January 2001).

CBO estimates that S. 543, if enacted, would increase premiums for group health insurance by an average of 0.9 percent, before accounting for the responses of health plans, employers, and workers to the higher premiums under the bill. Those responses would include reductions in the number of employers offering insurance to their employees and in the number of employees enrolling in employer-sponsored insurance, changes in the types of health plans that are offered, and reductions in the scope or generosity of health

insurance benefits, such as increased deductibles or higher copayments. CBO assumes that these behavioral responses would offset 60 percent of the potential impact of the bill on total health plan costs.

The remaining 40 percent of the potential increase in costs, or about 0.4 percent of group health insurance premiums, would occur in the form of increased outlays for health insurance. Those costs would be passed through to workers, reducing both their taxable compensation and other fringe benefits. For employees of private firms, CBO assumes that all of that increase would ultimately be passed through to workers. State, local, and tribal governments are assumed to absorb 75 percent of the increase and to reduce their workers' taxable income and other fringe benefits to offset the remaining one-quarter of the increase. CBO estimates that the resulting reduction in taxable income would grow from \$1.0 billion in calendar year 2002 to \$2.3 billion in 2011.

Those reductions in workers' taxable compensation would lead to lower federal tax revenues. CBO estimates that federal tax revenues would fall by \$230 million in 2002 and by \$5.4 billion over the 2002–2011 period if S. 543 were enacted. Social Security payroll taxes, which are off-budget, would account for about 30 percent of those totals.

Pay-as-you-go considerations: The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net change in governmental receipts that are subject to pay-as-you-go procedures are shown in the Table 2. (Only the changes in on-budget revenues are subject to pay-as-you-go procedures.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 2.—ESTIMATED EFFECTS OF S. 543 ON RECEIPTS AND DIRECT SPENDING

	By fiscal year, in millions of dollars—										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Change in Receipts	0	-150	-290	-330	-360	-370	-390	-410	-430	-450	-500
Change in Outlays											Not applicable

Estimated impact on state, local, and tribal governments: S. 543 would preempt state laws that have less stringent requirements for mental health coverage than those in this bill. That preemption would be an intergovernmental mandate as defined in UMRA. However, because the preemption would simply prohibit the application of state regulatory law, CBO estimates that the mandate would impose no significant costs on state, local, or tribal governments.

An existing provision in the Public Health Service Act would allow state, local, and tribal governments that operate group health plans for the benefit of their employees to opt out of the requirements of this bill. Consequently, those requirements would not be intergovernmental mandates as defined in UMRA, and the bill would affect the budgets of those governments only if they choose to comply with the requirements on group health plans. Roughly two-thirds of employees in state, local, and tribal governments are enrolled in self-insured plans.

The remaining governmental employees are enrolled in fully insured plans. Governments purchase health insurance for those employees through private insurers and would face increased premiums as a result of higher costs passed on to them by those insurers. The increased costs, however, would not result from intergovernmental mandates. Rather, they would be part of the mandate costs initially borne by the private sector and then passed on to the governments as purchasers of insurance. Assuming that in the absence of this legislation all mental health parity requirements would expire, CBO estimates that state, local, and tribal governments would face additional costs of \$150 million in 2002, increasing to about \$260 million in 2006. This estimate reflects the assumption that governments would shift roughly 25 percent of the additional costs to their employees.

Estimated impact on the private sector: The bill would impose a private-sector mandate on group health plans and issuers of group health insurance that provide medical and surgical benefits as well as mental health benefits. S. 543 would prohibit those entities from imposing treatment limitations or financial requirements for mental health benefits that differ from those placed on medical and surgical benefits. The requirements would not apply to coverage purchased by employer groups with fewer than 50 employees. Health plans that provided mental health benefits through a network of mental health providers would have to comply with the parity requirements for benefits provided by the network of providers but not for benefits provided by mental health professionals outside the network.

Under current law, the Mental Health Parity Act of 1996 prohibits group health plans and group health insurance issuers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on medical and surgical coverage. The current mandate is set to expire at the end of fiscal year 2001. Consequently, S. 543 would both extend and expand the current mandate requiring mental health parity.

CBO's estimate of the direct costs of the mandate assumes that affected entities would comply with S. 543 by further increasing the generosity of their mental health benefits. Many plans currently offer mental health benefits that are less generous than their medical and surgical benefits. We estimate that the direct costs of the additional services that would be newly covered by insurance because of the mandate would equal about 0.9 percent of employer-sponsored health insurance premiums compared to having no mandate at all.

The Unfunded Mandates Reform Act is unclear about how to measure the costs of extending an expiring mandate that has not yet expired. On the one hand, UMRA may be interpreted as requiring the direct costs to be measured relative to a case that assumes the current mandate will not exist beyond its expiration date. On the other hand, it also may be interpreted as requiring the direct costs to be measured relative to the cost of the existing mandate. CBO's estimate of the direct costs under each of those interpretations is displayed in Table 3.

Under the first interpretation, CBO estimates that the direct costs of the mandate in S.543 would be \$3.1 billion in 2002, rising to \$5.5 billion in 2006. Under the second interpretation, the direct

costs would be \$2.8 billion in 2002, rising to \$5.0 billion in 2006. In both cases, those costs would significantly exceed the threshold specified in UMRA (\$113 million in 2001, adjusted annually for inflation) in each year the mandate would be effective.

TABLE 3.—ESTIMATED DIRECT COSTS OF THE PRIVATE-SECTOR MANDATES IN S. 543

	By fiscal year, in millions of dollars—				
	2002	2003	2004	2005	2006
Direct costs compared with no mandate	3,100	4,500	4,800	5,100	5,500
Direct costs compared with the mandate in the Mental Health Parity Act of 1996	2,800	4,000	4,400	4,700	5,000

Estimate prepared by: Federal Costs: Jennifer Bowman and Alexis Ahlstrom. Impact on State, Local, and Tribal Governments: Leo Lex. Impact on the Private Sector: Jennifer Bowman, Stuart Hagen, and James Baumgardner.

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

V. APPLICATION OF LAW TO LEGISLATIVE BRANCH

The Committee finds that the legislation has no application to the legislative branch.

VI. REGULATORY IMPACT STATEMENT

Where suitable, the Committee intends the current regulations developed by the Department of Treasury, Department of Labor, and Department of Health and Human Services for the 1996 Mental Health Parity Act to apply to S. 543. The committee recognizes S. 543 is an expansion and change relative to the current law and calls upon the regulatory agencies to provide timely regulations. The committee has determined there will be only a minor increase in the regulatory burden of paperwork as the result of this legislation.

VII. SECTION-BY-SECTION ANALYSIS

Section 1—Short title

Section 1 specifies the title of the legislation as the “Mental Health Equitable Treatment Act of 2001”.

Section 2—Amendment to the Employee Retirement Income Security Act of 1974

Section 2 amends the Employee Retirement Income Security Act of 1974 by inserting section 712 “Mental Health Parity”.

Any group health plan that provides both medical and surgical benefits and mental health benefits shall not impose any treatment limits or financial requirements for mental illnesses unless comparable treatment limits or financial requirements are imposed for medical and surgical benefits.

Treatment limits include limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment.

Financial requirements include deductibles, coinsurance, co-payments, other cost sharing, and limitations on the total amount that

may be paid by a participant or beneficiary and include annual and lifetime limits.

Mental health benefits means benefits for services for all categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Services must be included as part of an authorized treatment plan that is in accordance with standard protocols and must meet the plan or issuer's medical necessity criteria. Benefits for treatment of substance abuse or chemical dependency are not included.

The legislation does not require health plans to provide any mental health benefits. However, if a plan provides mental health benefits, the benefits must be offered consistent with the parity requirements of the act.

Group health plans are not prevented from managing benefits as a means to contain costs and monitor and improve the quality of care.

The bill does not mandate coverage of specific mental health services, however it does require parity between mental health and physical health benefits.

Employers who had, on average, at least 2 and not more than 50 employees in the last year are exempt from the provisions of this act. The legislation does not apply to health insurance coverage offered in the individual market.

Companies that offer 2 or more benefit package options are required to offer parity for each plan. The company is not required to have parity between plans. Out-of-network benefits do not have to be provided at parity, as long as in-network benefits are provided at parity and a plan provides reasonable access to in-network providers and facilities.

Section 2 will apply to plan years on or after January 1, 2002.

Section 3—Amendment to the Public Health Service Act relating to the group market

Section 3 amends section 2705 of the Public Health Service Act with the identical provisions of Section 2.

Section 4—Preemption

The bill does not preempt State law if the law provides greater protections than those in the bill.

Section 5—General Accounting Office study

Within two years of enactment, the Comptroller General will conduct a study and prepare a report which evaluates the effect of this bill on the cost of health insurance coverage, access to coverage, and quality of health care.

VIII. VOTES IN COMMITTEE

S. 543 was brought up for markup at the Health, Education, Labor, and Pensions Executive Session on August 1, 2001. At that time, Senator Kennedy offered an amendment in the nature of a substitute which included several technical changes to clarify the language of the bill as well as several substantive changes. The substitute bill included a statement was added to reaffirm the ability of providers to manage their benefits. The substitute bill does not obligate insurers to cover specific services as long as parity is

kept between mental illness and medical and surgical benefits. The small employer exemption was changed to employers with less than 50 employees. Out-of-network benefits are not required to be covered consistent with the parity requirements of the act as long as beneficiaries are provided reasonable access to in-network providers and in-network benefits are provided at parity. Clarification was offered to ensure that self-insured plans are not subject to state regulations.

The manager's amendment was accepted by unanimous consent and the substitute bill was reported favorably from the Committee by a rollcall vote of 21 yeas to 0 nays.

Yeas: Kennedy; Dodd; Harkin; Mikulski; Jeffords; Bingaman; Wellstone; Murray; Reed; Edwards; Clinton; Gregg; Frist; Enzi; Hutchinson; Warner; Bond; Roberts; Collins; Sessions; and DeWine.

IX. COMMITTEE VIEWS

Coverage for all illnesses in the Diagnostic and Statistical Manual of Mental Disorders

The reported bill reflects the agreement of the committee and the intent of the sponsors to require the coverage of services for all mental illnesses listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, with the exception of substance abuse and chemical dependency. While the bill does not require a plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits, it prohibits insurers to limit coverage on the basis of a mental health diagnosis. That is, the bill does not allow insurers to choose specific illnesses or categories of illnesses in the DSM to exclude from coverage. This principle is consistent with the FEHBP.

Coverage of "specific services"

In including language regarding coverage for specific mental health services, the bill reflects an understanding that there may be circumstances under which a health plan would not provide specific mental health services. The principle that guides the establishment of such exclusions must, however, be the principle which provides the underpinning for the reported bill, the principle of parity. As stated in the bill, exclusions must not result in a disparity between the coverage of mental health and medical and surgical benefits. While the requirement that there be no such disparity is unequivocal, its application must reflect the broad purposes this legislation is intended to achieve.

The committee underscores the overriding principle of mental health parity in assuring access to efficacious treatment for mental illness. Accordingly, the language included in this bill regarding access to specific mental health services is not in any way intended to exclude the provision of any specific evidence-based services for covered mental health diagnoses when comparable health services are provided for medical or surgical benefits.

The philosophy underlying mental health parity is aptly reflected in an FEHBP Carrier Letter of April 11, 2000. That letter advises carriers that "[t]he overriding goal of parity is to expand the range of benefits offered while managing costs effectively." Specifically, regarding services, it states "[w]e also expect you to develop benefit

packages that will make effective use of available treatment methods. Since much successful treatment for mental health and substance abuse conditions is now being delivered through alternative modalities such as partial hospitalization and intensive outpatient care, we encourage a flexible approach to covering a continuum of care from a comprehensive group of facilities and providers.” The “specific services” language of the bill must be read in light of these statements and the FEHBP policy generally, which has guided the committee in developing the reported bill.

In using the DSM to define mental health, the committee intends to improve access to mental health benefits across the full range of diagnoses and eliminate discrimination on the basis of a specific mental illness, disorder, or diagnoses. At the same time, the committee included language allowing for the exclusion of specific services so long as such an exclusion does not violate parity between mental health benefits and medical/surgical benefits. The purpose of this provision was enable employers to voluntarily provide and design their benefits packages to meet the needs of their employees. An additional purpose of this provision is to ensure that S. 543 does not go beyond parity by de facto mandating the mental health benefits package. As with medical and surgical benefits, the committee expects that the selection of services will vary over time in response to clinical trials of effectiveness and improved standards of practice.

Thus, while S. 543 allows a plan to exclude a specific mental health service (so long as there is still parity between mental health and medical and surgical benefits), it does not allow a plan to exclude a specific mental illness, disorder, or diagnosis if it is listed in the DSM IV.

“Reasonable access” to in-network providers and facilities

In the June 7, 1999 carrier letter the FEHBP addresses out-of-network cost-sharing and day/visit limits with the following text: “HMOs may continue to limit services to network providers only, unless your Plan has a point-of-service option. All other delivery systems must give members the option to use non-network providers. However, we do not expect parity for out-of-network coverage so long as you meet reasonable standards for access to network providers and facilities. You may keep cost sharing, day/visit limits, and catastrophic maximums for out-of-network services for mental health and substance abuse at or near year 2000 levels.”

The bill allows insurers to have inequities in the provision of out-of-network benefits, however the committee clarifies that this provision can not be used to undermine the overall principle of the bill, parity. To address this point, the bill includes language that requires insurers to provide “reasonable access” to in-network providers. The committee intends the term “reasonable access” to mean comparable access as provided for medical and surgical benefits. Health benefit plans which severely limit access to in-network providers or significantly change cost sharing, day/visit limits, and catastrophic maximums for out-of-network services for mental health would be viewed as violating the spirit of the law.

Importance of recognizing impact of managed care

In addition to this modification regarding the status of benefits offered outside of a network, the inclusion in the reported legislation of explicit language recognizing the ability of group health plans to utilize preauthorization, networks of behavioral health providers, and other means of managing the mental health benefits required by the legislation is particularly important. As reflected in testimony provided to the Committee, numerous studies—as well as substantial evidence—regarding the cost impact of mental health benefits tend to show that mental health services can be covered in a cost-effective manner where they are managed through techniques such as those mentioned in section 712(b)(2) and section 2705(b)(2) of the legislation.

Importance of small employer exemption

As previously noted, the legislation exempts group health plans offered by employers with fewer than 50 employees. While recognizing that all individuals with mental illness deserve fair and equitable treatment in their health care coverage, the requirement for small business employers to provide parity raises particular issues. For the past three years, private health insurance premiums have risen significantly. While large and medium sized employers have, on average, experienced annual increases in the high single digits and low double digits in recent years, most small employers have faced increases double or triple that amount. Thus, the exemption recognizes the difficulty small employers in particular often have in balancing their desire to provide expanded health benefits to workers and concerns about affordability of those benefits.

X. ADDITIONAL VIEWS

The problem exists. Today, access to mental health services is more limited than it is for non-mental health services. At the same time, recent scientific advances have shed light on the causes of mental illness and have led to the development of more successful and cost-effective treatments. These developments raise concerns about the impact of health insurance benefits that impose more restrictions on mental health benefits than for other health benefits.

The impact is real. People living with untreated mental illness suffer, and the societal impact, while difficult to measure, takes a toll. Testimony before this Committee and information made available by those who suffer from mental illness, their families, and advocacy organizations representing them confirm the well-known impact on so many of our citizens. And research by the Washington Business Group on Health reveals that for some large employers, untreated mental illness has driven up other health care costs, increased absenteeism rates, and reduced overall corporate productivity.

The solution is simple. Take action to improve access to mental health services. No matter what action Congress takes now or in the future, we must not lose sight of this goal. Current law, the Mental Health Parity Act of 1996, has had a limited impact on access and is set to expire at the end of September, 2001. The "Mental Health Equitable Treatment Act" approved by the Committee on August 1, 2001, is much broader than current law and is intended to have a greater impact on access.

The modifications contained in the Chairman's substitute improve the original bill and should reduce the potential for unintended consequences that might have actually decreased access to mental health services. First, the Chairman's substitute recognizes the voluntary nature of our employer-based health benefits system by creating a non-discrimination bill as opposed to a mandated mental health benefits package. Second, the Chairman's substitute creates a small business exemption for employers with 50 or fewer employees. This exemption alleviates the concern that small employers may drop coverage altogether if the requirements are too costly. Third, the substitute recognizes the importance of managing behavioral health by expressly permitting such activities and applying the requirements only to in-network benefits when a plan offers such a feature.

There is one additional concern that I believe is not addressed by the original bill or the Chairman's substitute. That is the overall cost impact of this bill and its long term impact on access to mental health services as well as non-mental health services. The CBO recently scored this bill as increasing costs by an average of 0.9 percent for group health plans. Alone, this score is significant and will adversely impact health premiums and access to health benefits.

Combined with double-digit premium trends, the cost of the Patients' Bill of Rights (around 4%), medical privacy rules, and other potential mandates, there is no question that action Congress takes with this bill and others will impact access to health care. In addition, and significantly, CBO notes that the legislation will reduce federal tax revenues by \$230 million in 2002 and by \$5.4 billion over the 2002–2011 period.

The CBO cost impact estimate is an average across all types of plans, and the official score does not distinguish based on plan type. However, analysis conducted by the National Institute of Mental Health (NIMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Washington Business Group on Health (WBGH), and Price Waterhouse Coopers (PWC) examined the impact of mental health parity based on plan type. Each of these studies draws the same conclusion. Mental health parity can be achieved at minimal cost if, and only if, the benefits are "tightly" or "comprehensively" managed. For instance, PWC estimates that S. 543 will increase costs by 1.2% for an HMO plan with a gatekeeper and 4.2% for a fee-for-service plan. This has been the guiding principle OPM has used in implementing mental health parity for federal employees and is the reason that parity is only applied to in-network benefits under FEHBP.

The CBO score is based on current law and does not take into account passage of other bills Congress is considering. Both the House and Senate have recently passed patients' rights laws that are designed to curb a range of managed care practices. Since there is unanimous agreement that mental health parity is cost-effective when provided in a managed care setting, I am deeply concerned about the interaction between S. 543 and patients' rights legislation, which is on the brink of passage. By curtailing the use of certain managed care tools through patients' rights legislation, the cost of mental health parity may be greater than anticipated. Moreover, consumer demand has already led to a migration away from more tightly managed plans, which may also impact the cost of mental health parity in the future.

It is my hope that by the time the Senate takes action on legislation, we will have a better understanding of the interaction between these two bills and its potential impact on access to mental health benefits. As I stated at the Committee markup, I believe the cost concern is very real and hope it will be addressed on the Senate floor. If our goal is to improve access to mental services, then it is our responsibility to safeguard against any unanticipated cost consequences that undermine this goal.

I look forward to working with the mental health community, my Senate colleagues, and other interested parties in advancing this legislation and improving access to mental health services.

JUDD GREGG.

XI. CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

[SEC. 2705. [300gg-5] PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

[(a) IN GENERAL.—

[(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

[(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

[(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

[(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

[(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

[(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate-lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that it computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

[(2) ANNUAL LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

[(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

[(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

[(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

[(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

[(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

[(b) CONSTRUCTION.—Nothing in this section shall be construed—

[(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

[(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

[(c) EXEMPTIONS.—

[(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

[(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) re-

sults in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

[(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.]

[(e) DEFINITIONS.—For purposes of this section—

[(1) AGGREGATE LIFETIME LIMIT.—The term “aggregate lifetime limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.]

[(2) ANNUAL LIMIT.—The term “annual limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.]

[(3) MEDICAL OR SURGICAL BENEFITS.—The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.]

[(4) MENTAL HEALTH BENEFITS.—The term “mental health benefits” means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.]

[(f) SUNSET.—This section shall not apply to benefits for services furnished on or after September 30, 2001.]

SEC. 2705. MENTAL HEALTH PARITY.

(a) *IN GENERAL.*—*In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not impose any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits.*

(b) *CONSTRUCTION.*—

(1) *IN GENERAL.*—*Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.*

(2) *MEDICAL MANAGEMENT OF MENTAL HEALTH BENEFITS.*—*Nothing in this section shall be construed to prevent the medical management of mental health benefits, including through concurrent and retrospective utilization review and utilization management practices, preauthorization, and the application of medical necessity and appropriateness criteria applicable to behavioral health and the contracting and use of a network of participating providers.*

(3) *NO REQUIREMENT OF SPECIFIC SERVICES.*—Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.

(c) *SMALL EMPLOYER EXEMPTION.*—

(1) *IN GENERAL.*—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of any employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year.

(2) *APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.*—For purposes of this subsection—

(A) *APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.*—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

(B) *EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.*—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

(d) *SEPARATE APPLICATION TO EACH OPTION OFFERED.*—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option. In the case of any plan or coverage option that provides in-network mental health benefits, out-of-network mental health benefits maybe provided using treatment limitations or financial requirements that are not comparable to the limitations and requirements applied to medical and surgical benefits if the plan or coverage provides such in-network mental health benefits in accordance with subsection (a) and provides reasonable access to in-network providers and facilities.

(e) *DEFINITIONS.*—For purposes of this section—

(1) *FINANCIAL REQUIREMENTS.*—The term “financial requirements” includes deductibles, coinsurance, co-payments, other cost sharing, and limitations on the total amount that may be paid by a participant, beneficiary or enrollee with respect to benefits under the plan or health insurance coverage and shall include the application of annual and lifetime limits.

(2) *MEDICAL OR SURGICAL BENEFITS.*—The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or cov-

erage (as the case may be) but does not include mental health benefits.

(3) *MENTAL HEALTH BENEFITS.*—The term “mental health benefits” means benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR)*, or the most recent edition if different than the *Fourth Edition*, if such services are included as part of an authorized treatment plan that is in accordance with standard protocols and such services meet the plan or issuer’s medical necessity criteria. Such term does not include benefits with respect to the treatment of substance abuse or chemical dependency.

(4) *TREATMENT LIMITATIONS.*—The term “treatment limitations” means limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment under the plan or coverage.

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**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
1974**

* * * * *

[SEC. 712. [1185a] PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

[(a) IN GENERAL.—

[(1) AGGREGATE LIFETIME LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

[(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

[(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

[(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

[(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

[(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical

benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

[(2) ANNUAL LIMITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

[(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

[(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

[(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

[(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

[(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

[(b) CONSTRUCTION.—Nothing in this section shall be construed—

[(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

[(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

[(c) EXEMPTIONS.—

[(1) SMALL EMPLOYER EXEMPTION.—

[(A) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

[(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

[(C) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this paragraph—

[(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the International Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

[(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

[(iii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

[(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

[(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

[(e) DEFINITIONS.—For purposes of this section—

[(1) AGGREGATE LIFETIME LIMIT.—The term “aggregate lifetime limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

[(2) ANNUAL LIMIT.—The term “annual limit” means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

[(3) **MEDICAL OR SURGICAL BENEFITS.**—The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.]

[(4) **MENTAL HEALTH BENEFITS.**—The term “mental health benefits” means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.]

[(f) **SUNSET.**—This section shall not apply to benefits for services furnished on or after September 30, 2001.]

SEC. 712. MENTAL HEALTH PARITY.

(a) **IN GENERAL.**—*In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not impose any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits.*

(b) **CONSTRUCTION.**—

(1) **IN GENERAL.**—*Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.*

(2) **MEDICAL MANAGEMENT OF MENTAL HEALTH BENEFITS.**—*Consistent with subsection (a), nothing in this section shall be construed to prevent the medical management of mental health benefits, including through concurrent and retrospective utilization review and utilization management practices, preauthorization, and the application of medical necessity and appropriateness criteria applicable to behavioral health and the contracting and use of a network of participating providers.*

(3) **NO REQUIREMENT OF SPECIFIC SERVICES.**—*Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide coverage for specific mental health services, except to the extent that the failure to cover such services would result in a disparity between the coverage of mental health and medical and surgical benefits.*

(c) **SMALL EMPLOYERS EXEMPTION.**—

(1) **IN GENERAL.**—*This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of any employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year.*

(2) **APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.**—*For purposes of this subsection—*

(A) **APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.**—*Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.*

(B) *EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.*—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

(d) *SEPARATE APPLICATION TO EACH OPTION OFFERED.*—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) *IN-NETWORK AND OUT-OF-NETWORK RULES.*—In the case of a plan or coverage option that provides in-net-work mental health benefits, out-of-network mental health benefits may be provided using treatment limitations or financial requirements that are not comparable to the limitations and requirements applied to medical and surgical benefits if the plan or coverage provides such in-net-work mental health benefits in accordance with subsection (a) and provides reasonable access to in-network providers and facilities.

(f) *DEFINITIONS.*—For purposes of this section—

(1) *FINANCIAL REQUIREMENTS.*—The term “financial requirements” includes deductibles, coinsurance, co-payments, other cost sharing, and limitations on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan or health insurance coverage and shall include the application of annual and lifetime limits.

(2) *MEDICAL OR SURGICAL BENEFITS.*—The term “medical or surgical benefits” means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(3) *MENTAL HEALTH BENEFITS.*—The term “mental health benefits” means benefits with respect to services, as defined under the terms and conditions of the plan or coverage (as the case may be), for all categories of mental health conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV-TR)*, or the most recent edition if different than the *Fourth Edition*, if such services are included as part of an authorized treatment plan that is in accordance with standard protocols and such services meet the plan or issuer’s medical necessity criteria. Such term does not include benefits with respect to the treatment of substance abuse or chemical dependency.

(4) *TREATMENT LIMITATIONS.*—The term “treatment limitations” means limitations on the frequency of treatment, number

of visits or days of coverage, or other similar limits on the duration or scope of treatment under the plan or coverage.

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