

PROVIDING FOR CONSIDERATION OF THE BILL (H.R. 1424) TO AMEND SECTION 712 OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, SECTION 2705 OF THE PUBLIC HEALTH SERVICE ACT, AND SECTION 9812 OF THE INTERNAL REVENUE CODE OF 1986 TO REQUIRE EQUITY IN THE PROVISION OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS UNDER GROUP HEALTH PLANS

MARCH 4, 2008.—Referred to the House Calendar and ordered to be printed

Ms. CASTOR, from the Committee on Rules,
submitted the following

R E P O R T

[To accompany H. Res. 1014]

The Committee on Rules, having had under consideration House Resolution 1014, by a nonrecord vote report the same to the House with the recommendation that the resolution be adopted.

SUMMARY OF PROVISIONS OF THE RESOLUTION

The resolution provides for consideration of H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, under a closed rule providing two hours of general debate in the House with 40 minutes equally divided and controlled by the Chairman and Ranking Minority Member of the Committee on Energy and Commerce, 40 minutes equally divided and controlled by the Chairman and Ranking Minority Member of the Committee on Ways and Means, and 40 minutes equally divided and controlled by the Chairman and Ranking Minority Member of the Committee on Education and Labor. The rule waives all points of order against consideration of the bill except for clauses 9 and 10 of rule XXI. The rule provides that the bill shall be considered as read. The rule provides that in lieu of the amendments recommended by the Committees on Energy and Commerce, Ways and Means, and Education and Labor, the amendment in the nature of a substitute printed in this report shall be considered as adopted. The rule waives all points of order against the bill as amended. This waiver does not affect the point of order available under clause 9 of rule XXI (regarding earmark disclosure). The rule provides one motion to recommit with or without instructions. The rule provides that in the engrossment of H.R. 1424, the text of H.R. 493, as passed the House, shall be added at the end of H.R. 1424. Finally, the rule

provides that the Chair may postpone further consideration of the bill to a time designated by the Speaker.

EXPLANATION OF WAIVERS

The waiver of all points of order against consideration of the bill (except for clauses 9 and 10 of rule XXI) includes a waiver of rule XIII, clause 4(a), requiring a three-day layover of the committee report and a waiver of rule XIII clause 3(c) regarding the statement of performance goals in committee reports. Although the rule waives all points of order against the provisions in the bill, as amended, the Committee is not aware of any points of order. The waiver of all points of order is prophylactic.

COMMITTEE VOTES

The results of each record vote on an amendment or motion to report, together with the names of those voting for and against, are printed below:

Rules Committee record vote No. 441

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Dreier.

Summary of motion: To make in order and provide appropriate waivers for an amendment submitted by Reps. Wilson, Heather (NM)/Kline (MN)/Camp (MI), #11, which provides a substitute for the language of H.R. 1424 by incorporating the text of S. 558. The amendment also includes a provision that requires all states to implement an electronic asset-verification program for Medicaid eligibility verification.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 442

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Dreier.

Summary of motion: To make in order and provide appropriate waivers for an amendment by Rep. Barton (TX), #3, which provides that, to the extent the requirements of DSM apply, plans shall also maintain coverage for mental health disorders or conditions arising out of abortions, or loss of an unborn child.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 443

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Dreier.

Summary of motion: To make in order and provide appropriate waivers for an amendment by Rep. Barton (TX), #4, which provides that nothing about codification of the DSM creates a defense in

criminal cases including for child abusers. Nothing about the codification of the DSM overrides any requirements for reporting of criminal conduct, including for child abusers, or creates any new privilege against disclosure.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 444

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Hastings (WA).

Summary of motion: To make in order and provide appropriate waivers for an amendment by Rep. Hastings (WA) and Rep. McMorris (WA), #7, which removes the prohibition on physician referral to hospitals that are more than 40 percent doctor owned. The amendment also removes the limitation on hospital facility expansion.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 445

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Hastings (WA).

Summary of motion: To make in order and provide appropriate waivers for the amendments en bloc by Reps. Hastings (WA) and McMorris (WA), #8, which removes the prohibition on physician referral to hospitals that are more than 40 percent doctor owned and the limitation on hospital facility expansion for hospitals that meet the following requirements: (1) over half of their care is provided to Medicare and Medicaid patients and (2) have obtained a certificate of need from the state; and the amendment by Rep. Hastings (WA) and Rep. McMorris (WA), #9, which removes the prohibition on physician referral to hospitals that are more than 40 percent doctor owned and the limitation on hospital facility expansion in cases where the Governor submits written notice to the Secretary that the hospital is needed to maintain an adequate level of access to care in the state.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 446

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Hastings (WA).

Summary of motion: To make in order and provide appropriate waivers for an amendment by Rep. Hinojosa (TX), #5, which exempts large full service hospitals from the ownership requirements and would make it easier for large full service hospitals to qualify

for the expansion exception. The amendment would allow the Secretary to disallow the grandfather if there is overutilization.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

Rules Committee record vote No. 447.

Date: March 4, 2008.

Measure: H.R. 1424.

Motion by: Mr. Hastings (WA).

Summary of motion: To make in order and provide appropriate waivers for an amendment by Rep. Broun (GA), #2, which strikes the increased cost exemption for plans in the bill, reverting to the existing law which exempts firms whose costs rise 1% as a result of the federal mandates.

Results: Defeated 2–7.

Vote by Members: McGovern—Nay, Hastings (FL)—Nay; Matsui—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Hastings (WA)—Yea.

SUMMARY OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO BE CONSIDERED AS ADOPTED

The Amendment in the Nature of a Substitute expands the Mental Health Parity Act of 1996 to provide for equity in the terms of employer sponsored health benefits for mental health and substance-related disorders compared to medical and surgical disorders. It ensures that health plans do not charge higher copayments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than for medical and surgical benefits. The Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service can penalize insurers for discriminatory practices in plan design under this bill and individuals may sue in court to obtain promised benefits. It includes an increase in the rebate, or discount, that pharmaceutical companies are required to provide to State Medicaid programs for drugs provided to Medicaid beneficiaries. It includes language to prohibit physicians from referring patients to hospitals in which they have an ownership interest, but also provides the ability to grandfather and grow existing physician-owned hospitals.

TEXT OF THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO BE CONSIDERED AS ADOPTED

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

Sec. 2. Amendments to the Employee Retirement Income Security Act of 1974.

Sec. 3. Amendments to the Public Health Service Act relating to the group market.

Sec. 4. Amendments to the Internal Revenue Code of 1986.

Sec. 5. Medicaid drug rebate.

Sec. 6. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.

Sec. 7. Studies and reports.

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

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

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

“(3) **TREATMENT LIMITS.**—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

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

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

“(i) **INPATIENT, IN-NETWORK.**—Items and services not described in clause (v) furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

“(ii) **INPATIENT, OUT-OF-NETWORK.**—Items and services not described in clause (v) furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

“(iii) **OUTPATIENT, IN-NETWORK.**—Items and services not described in clause (v) furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

“(iv) **OUTPATIENT, OUT-OF-NETWORK.**—Items and services not described in clause (v) furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

“(v) EMERGENCY CARE.—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

“(4) BENEFICIARY FINANCIAL REQUIREMENTS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

“(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

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

items and services, the plan or coverage may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that results in greater out-of-pocket expenses to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

“(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—

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

(2) in subsection (b)—

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

(B) by striking “; or” and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking “mental health benefits” each place it appears (other than in any provision amended by paragraph (2)) and inserting “mental health or substance-related disorder benefits”,

(2) by striking “mental health benefits” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting “mental health and substance-related disorder benefits”, and

(3) in subsection (e), by striking paragraph (4) and inserting the following new paragraphs:

“(4) MENTAL HEALTH BENEFITS.—The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable law, but does not include substance-related disorder benefits.

“(5) SUBSTANCE-RELATED DISORDER BENEFITS.—The term ‘substance-related disorder benefits’ means benefits with respect to services for substance-related disorders, as defined under the terms of the plan and in accordance with applicable law.”.

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

“(5) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offer-

ing such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health and substance-related disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.”.

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

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

“(A) **MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.**—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

“(I) **EMERGENCY.**—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

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

“(2) INCREASED COST EXEMPTION.—

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

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

“(i) 2 percent in the case of the first plan year to which this paragraph applies; and

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

“(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this subsection shall be made in writing and prepared and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be made available by the plan administrator (or health insurance issuer, as the case may be) to the general public.

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

“(E) NOTIFICATION.—An election to modify coverage of mental health and substance-related disorder benefits as permitted under this paragraph shall be treated as a material modification in the terms of the plan as described in section 102(a) and notice of which shall be provided a reasonable period in advance of the change.

“(F) NOTIFICATION OF APPROPRIATE AGENCY.—

“(i) IN GENERAL.—A group health plan that, based on a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall notify the Department of Labor of such election.

“(ii) REQUIREMENT.—A notification under clause (i) shall include—

“(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

“(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

“(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

“(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Department of Labor shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

“(I) a breakdown of States by the size and any type of employers submitting such notification; and

“(II) a summary of the data received under clause (ii).

“(G) NO IMPACT ON APPLICATION OF STATE LAW.—The fact that a plan or coverage is exempt from the provisions of this section under subparagraph (A) shall not affect the application of State law to such plan or coverage.

“(H) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan (or health insurance coverage offered in connection with such a plan) from complying with the provisions of this section notwithstanding that the plan or coverage is not required to comply with such provisions due to the application of subparagraph (A).”

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

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

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

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

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

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

“(1) IN GENERAL.—This part shall not be construed to supersede any provision of State law which establishes, implements,

or continues in effect any consumer protections, benefits, methods of access to benefits, rights, external review programs, or remedies solely relating to health insurance issuers in connection with group health insurance coverage (including benefit mandates or regulation of group health plans of 50 or fewer employees) except to the extent that such provision prevents the application of a requirement of this part.

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

“(3) OTHER STATE LAWS.—Nothing in this section shall be construed to exempt or relieve any person from any laws of any State not solely related to health insurance issuers in connection with group health coverage insofar as they may now or hereafter relate to insurance, health plans, or health coverage.”

(i) CONFORMING AMENDMENTS TO HEADING.—

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

“SEC. 712. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.”

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

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

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 2009.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(k) DOL ANNUAL SAMPLE COMPLIANCE.—The Secretary of Labor shall annually sample and conduct random audits of group health plans (and health insurance coverage offered in connection with such plans) in order to determine their compliance with the amendments made by this Act and shall submit to the appropriate committees of Congress an annual report on such compliance with such amendments. The Secretary shall share the results of such audits

with the Secretaries of Health and Human Services and of the Treasury.

(1) ASSISTANCE TO PARTICIPANTS AND BENEFICIARIES.—The Secretary of Labor shall provide assistance to participants and beneficiaries of group health plans with any questions or problems with compliance with the requirements of this Act. The Secretary shall notify participants and beneficiaries how they can obtain assistance from State consumer and insurance agencies and the Secretary shall coordinate with State agencies to ensure that participants and beneficiaries are protected and afforded the rights provided under this Act.

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

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

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

“(3) TREATMENT LIMITS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

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

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

“(i) INPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

“(ii) INPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and outside any network of providers established or recognized under such plan or coverage.

“(iii) OUTPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and within a network of providers established or recognized under such plan or coverage.

“(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and outside any network of providers established or recognized under such plan or coverage.

“(v) EMERGENCY CARE.—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

“(4) BENEFICIARY FINANCIAL REQUIREMENTS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

“(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

and surgical benefits and such mental health and substance-related disorder benefits.

“(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan or coverage includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan or coverage may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that results in greater out-of-pocket expenses to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

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

(2) in subsection (b)—

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

(B) by striking “; or” and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking “mental health benefits” each place it appears (other than in any provision amended by paragraph (2)) and inserting “mental health or substance-related disorder benefits”,

(2) by striking “mental health benefits” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting “mental health and substance-related disorder benefits”, and

(3) in subsection (e), by striking paragraph (4) and inserting the following new paragraphs:

“(4) MENTAL HEALTH BENEFITS.—The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable law, but does not include substance-related disorder benefits.

“(5) SUBSTANCE-RELATED DISORDER BENEFITS.—The term ‘substance-related disorder benefits’ means benefits with respect to services for substance-related disorders, as defined under the terms of the plan and in accordance with applicable law.”.

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

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

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

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

“(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

“(I) EMERGENCY.—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

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

“(2) INCREASED COST EXEMPTION.—

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

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

“(i) 2 percent in the case of the first plan year to which this paragraph applies; and

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

“(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this subsection shall be made in writing and prepared and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be made available by the plan administrator (or health insurance issuer, as the case may be) to the general public.

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

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

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

“(F) NOTIFICATION OF APPROPRIATE AGENCY.—

“(i) IN GENERAL.—A group health plan that, based on a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall notify the Secretary of Health and Human Services of such election.

“(ii) REQUIREMENT.—A notification under clause (i) shall include—

“(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

“(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

“(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

“(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Secretary of Health and Human Services shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

“(I) a breakdown of States by the size and any type of employers submitting such notification; and

“(II) a summary of the data received under clause (ii).

“(G) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan (or health insurance coverage offered in connection with such a plan) from complying with the provisions of this section notwithstanding that the plan or coverage is not required to comply with such provisions due to the application of subparagraph (A).”.

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

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

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

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

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

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

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

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

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

“SEC. 2705. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.”.

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

(2) ELIMINATION OF SUNSET.—The amendment made by subsection (g) shall apply to benefits for services furnished after December 31, 2007.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 2009.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

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

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

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

“(3) TREATMENT LIMITS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

plan may not impose any treatment limit on mental health or substance-related disorder benefits that are classified in the same category of items or services.

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

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

“(i) INPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and within a network of providers established or recognized under such plan.

“(ii) INPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an inpatient basis and outside any network of providers established or recognized under such plan.

“(iii) OUTPATIENT, IN-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and within a network of providers established or recognized under such plan.

“(iv) OUTPATIENT, OUT-OF-NETWORK.—Items and services not described in clause (v) furnished on an outpatient basis and outside any network of providers established or recognized under such plan.

“(v) EMERGENCY CARE.—Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

“(4) BENEFICIARY FINANCIAL REQUIREMENTS.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits—

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

“(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

“(ii) OTHER FINANCIAL REQUIREMENTS.—If the plan includes a beneficiary financial requirement not described in clause (i) on substantially all medical and surgical benefits within a category of items and services, the plan may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that results in greater out-of-pocket expenses to the participant or beneficiary than the predominant beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category.

“(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—

For purposes of this paragraph, the term ‘beneficiary financial requirement’ includes, with respect to a plan, any deductible, coinsurance, co-payment, other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan, but does not include the application of any aggregate lifetime limit or annual limit.”, and

(2) in subsection (b)—

(A) by striking “construed—” and all that follows through “(1) as requiring” and inserting “construed as requiring”,

(B) by striking “; or” and inserting a period, and

(C) by striking paragraph (2).

(b) EXPANSION TO SUBSTANCE-RELATED DISORDER BENEFITS AND REVISION OF DEFINITION.—Section 9812 of such Code is further amended—

(1) by striking “mental health benefits” each place it appears (other than in any provision amended by paragraph (2)) and inserting “mental health or substance-related disorder benefits”,

(2) by striking “mental health benefits” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C) and inserting “mental health and substance-related disorder benefits”, and

(3) in subsection (e), by striking paragraph (4) and inserting the following new paragraphs:

“(4) MENTAL HEALTH BENEFITS.—The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable law, but does not include substance-related disorder benefits.

“(5) SUBSTANCE-RELATED DISORDER BENEFITS.—The term ‘substance-related disorder benefits’ means benefits with respect to services for substance-related disorders, as defined under the terms of the plan and in accordance with applicable law.”.

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

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

(d) MINIMUM BENEFIT REQUIREMENTS.—Subsection (a) of section 9812 of such Code is further amended by adding at the end the following new paragraph:

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

“(A) MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—In the case of a group health plan that provides any mental health or substance-related disorder benefits, the plan shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

“(I) EMERGENCY.—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health or substance-related disorders).

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

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

(e) REVISION OF INCREASED COST EXEMPTION.—Paragraph (2) of section 9812(c) of such Code is amended to read as follows:

“(2) INCREASED COST EXEMPTION.—

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

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

“(i) 2 percent in the case of the first plan year to which this paragraph applies, and

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

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

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

“(E) NOTIFICATION OF APPROPRIATE AGENCY.—

“(i) IN GENERAL.—A group health plan that, based on a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall notify the Secretary of the Treasury of such election.

“(ii) REQUIREMENT.—A notification under clause (i) shall include—

“(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

“(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related disorder benefits under the plan; and

“(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance-related disorder benefits under the plan.

“(iii) CONFIDENTIALITY.—A notification under clause (i) shall be confidential. The Secretary of the Treasury shall make available, upon request to the appropriate committees of Congress and on not more than an annual basis, an anonymous itemization of such notifications, that includes—

“(I) a breakdown of States by the size and any type of employers submitting such notification; and

“(II) a summary of the data received under clause (ii).

“(F) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a group health plan from complying with the provisions of this section notwithstanding that the plan is not required to comply with such provisions due to the application of subparagraph (A).”.

(f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOYERS.—Paragraph (1) of section 9812(c) of such Code is amended to read as follows:

“(1) **SMALL EMPLOYER EXEMPTION.**—

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

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

(g) **ELIMINATION OF SUNSET PROVISION.**—Section 9812 of such Code is amended by striking subsection (f).

(h) **CONFORMING AMENDMENTS TO HEADING.**—

(1) **IN GENERAL.**—The heading of section 9812 of such Code is amended to read as follows:

“**SEC. 9812. EQUITY IN MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.**”

(2) **CLERICAL AMENDMENT.**—The table of sections for subchapter B of chapter 100 of such Code is amended by striking the item relating to section 9812 and inserting the following new item:

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

(i) **EFFECTIVE DATE.**—

(1) **IN GENERAL.**—Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to plan years beginning on or after January 1, 2009.

(2) **ELIMINATION OF SUNSET.**—The amendment made by subsection (g) shall apply to benefits for services furnished after December 31, 2007.

(3) **SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.**—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section (other than subsection (g)) shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) January 1, 2009.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 5. MEDICAID DRUG REBATE.

Paragraph (1)(B)(i) of section 1927(c) of the Social Security Act (42 U.S.C. 1396r-8(c)) is amended—

- (1) by striking “and” at the end of subclause (IV);
- (2) in subclause (V)—
 - (A) by inserting “and before January 1, 2009, and after December 31, 2014,” after “December 31, 1995,”; and
 - (B) by striking the period at the end and inserting “; and”; and
- (3) by adding at the end the following new subclause:
 - “(VI) after December 31, 2008, and before January 1, 2015, is 20.1 percent.”.

SEC. 6. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

- (1) in subsection (d)(2)—
 - (A) in subparagraph (A), by striking “and” at the end;
 - (B) in subparagraph (B), by striking the period at the end and inserting “; and”; and
 - (C) by adding at the end the following new subparagraph:
 - “(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).”;
- (2) in subsection (d)(3)—
 - (A) in subparagraph (B), by striking “and” at the end;
 - (B) in subparagraph (C), by striking the period at the end and inserting “; and”; and
 - (C) by adding at the end the following new subparagraph:
 - “(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.”; and

(3) by adding at the end the following new subsection:

“(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

“(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

“(A) PROVIDER AGREEMENT.—The hospital had—

“(i) physician ownership on the date of enactment of this subsection; and

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

“(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—

Except as provided in paragraph (3), the number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

“(C) PREVENTING CONFLICTS OF INTEREST.—

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

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

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

“(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

“(I) the ownership interest of such referring physician in the hospital; and

“(II) if applicable, any such ownership interest of the treating physician.

“(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

“(iv) The hospital discloses the fact that the hospital is partially owned by physicians—

“(I) on any public website for the hospital; and

“(II) in any public advertising for the hospital.

“(D) ENSURING BONA FIDE INVESTMENT.—

“(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

“(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

“(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

“(iv) The hospital (or any investors in the hospital) does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

“(v) The hospital (or any investors in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

“(vi) Investment returns are distributed to each investor in the hospital in an amount that is directly proportional to the investment of capital by such investor in the hospital.

“(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

“(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the

terms offered to an individual who is not a physician owner.

“(E) PATIENT SAFETY.—

“(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

“(I) the hospital discloses such fact to a patient; and

“(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

“(ii) The hospital has the capacity to—

“(I) provide assessment and initial treatment for patients; and

“(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

“(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

“(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

“(A) PROCESS.—

“(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

“(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community that the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

“(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on the date that is 18 months after the date of enactment of this subsection.

“(iv) REGULATIONS.—Not later than the date that is 18 months after the date of enactment of this subsection, the Secretary shall promulgate regulations to carry out the process under clause (i).

“(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

“(C) PERMITTED INCREASE.—

“(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms and beds of the applicable hospital above the baseline number of operating rooms and beds of the applicable hospital

(or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms and beds of the hospital after the application of the most recent increase under such an exception) by an amount determined appropriate by the Secretary.

“(ii) LIFETIME 50 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms and beds of an applicable hospital under clause (i) to the extent such increase would result in the number of operating rooms and beds of the applicable hospital exceeding 150 percent of the baseline number of operating rooms and beds of the applicable hospital.

“(iii) BASELINE NUMBER OF OPERATING ROOMS AND BEDS.—In this paragraph, the term ‘baseline number of operating rooms and beds’ means the number of operating rooms and beds of the applicable hospital as of the date of enactment of this subsection.

“(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms and beds of an applicable hospital pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

“(E) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital—

“(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 200 percent of the percentage increase in the population growth of the United States during that period, as estimated by Bureau of the Census;

“(ii) whose annual percent of total inpatient admissions and outpatient visits that represent inpatient admissions and outpatient visits under the program under title XIX is equal to or greater than the average percent with respect to such admissions and visits for all hospitals located in the State;

“(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;

“(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

“(v) in the case of a hospital located—

“(I) in a core-based statistical area, that is located in such an area in which the average bed occupancy rate in such area is greater than 80 percent; or

“(II) outside of a core-based statistical area, that is located in a State in which the average bed occupancy rate is greater than 80 percent.

“(F) PUBLICATION OF FINAL DECISIONS.—The Secretary shall publish final decisions with respect to applications under this paragraph in the Federal Register.

“(G) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

“(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

“(5) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term ‘physician owner’ means a physician (or an immediate family member of such physician) with a direct or an indirect ownership interest in the hospital.”.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

(c) ADJUSTMENT TO PAQI FUND.—Section 1848(l)(2)(A)(i)(III) of the Social Security Act (42 U.S.C. 1395w-4(l)(2)(A)(i)(III)), as amended by section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), is amended by striking “\$4,960,000,000” and inserting “\$5,120,000,000”.

SEC. 7. STUDIES AND REPORTS.

(a) IMPLEMENTATION OF ACT.—

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

- (A) the cost of health insurance coverage;
- (B) access to health insurance coverage (including the availability of in-network providers);
- (C) the quality of health care;
- (D) Medicare, Medicaid, and State and local mental health and substance abuse treatment spending;
- (E) the number of individuals with private insurance who received publicly funded health care for mental health and substance-related disorders;
- (F) spending on public services, such as the criminal justice system, special education, and income assistance programs;
- (G) the use of medical management of mental health and substance-related disorder benefits and medical necessity determinations by group health plans (and health insurance issuers offering health insurance coverage in connection with such plans) and timely access by participants

and beneficiaries to clinically-indicated care for mental health and substance-use disorders; and

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

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

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

(c) DOL BIENNIAL REPORT ON ANY OBSTACLES IN OBTAINING COVERAGE.—Every two years, the Secretary of Labor, in consultation with the Secretaries of Health and Human Services and the Treasury, shall submit to the appropriate committees of each House of the Congress a report on obstacles, if any, that individuals face in obtaining mental health and substance-related disorder care under their health plans.