

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

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

Strike all after the enacting clause and insert the following:

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

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

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

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

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

9 (a) EXTENSION OF PARITY TO TREATMENT LIMITS  
 10 AND BENEFICIARY FINANCIAL REQUIREMENTS.—Section  
 11 712 of the Employee Retirement Income Security Act of  
 12 1974 (29 U.S.C. 1185a) is amended—

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

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

7 “(A) NO TREATMENT LIMIT.—If the plan  
8 or coverage does not include a treatment limit  
9 (as defined in subparagraph (D)) on substan-  
10 tially all medical and surgical benefits in any  
11 category of items or services, the plan or cov-  
12 erage may not impose any treatment limit on  
13 mental health or substance-related disorder  
14 benefits that are classified in the same category  
15 of items or services.

16 “(B) TREATMENT LIMIT.—If the plan or  
17 coverage includes a treatment limit on substan-  
18 tially all medical and surgical benefits in any  
19 category of items or services, the plan or cov-  
20 erage may not impose such a treatment limit on  
21 mental health or substance-related disorder  
22 benefits for items and services within such cat-  
23 egory that is more restrictive than the predomi-  
24 nant treatment limit that is applicable to med-

1           ical and surgical benefits for items and services  
2           within such category.

3                   “(C) CATEGORIES OF ITEMS AND SERV-  
4           ICES FOR APPLICATION OF TREATMENT LIMITS  
5           AND BENEFICIARY FINANCIAL REQUIRE-  
6           MENTS.—For purposes of this paragraph and  
7           paragraph (4), there shall be the following five  
8           categories of items and services for benefits,  
9           whether medical and surgical benefits or mental  
10          health and substance-related disorder benefits,  
11          and all medical and surgical benefits and all  
12          mental health and substance related benefits  
13          shall be classified into one of the following cat-  
14          egories:

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

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

1                   “(iii) OUTPATIENT, IN-NETWORK.—

2                   Items and services not described in clause  
3                   (v) furnished on an outpatient basis and  
4                   within a network of providers established  
5                   or recognized under such plan or coverage.

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

12                  “(v) EMERGENCY CARE.—Items and  
13                  services, whether furnished on an inpatient  
14                  or outpatient basis or within or outside  
15                  any network of providers, required for the  
16                  treatment of an emergency medical condi-  
17                  tion (as defined in section 1867(e) of the  
18                  Social Security Act, including an emer-  
19                  gency condition relating to mental health  
20                  or substance-related disorders).

21                  “(D) TREATMENT LIMIT DEFINED.—For  
22                  purposes of this paragraph, the term ‘treatment  
23                  limit’ means, with respect to a plan or coverage,  
24                  limitation on the frequency of treatment, num-  
25                  ber of visits or days of coverage, or other simi-

1           lar limit on the duration or scope of treatment  
2           under the plan or coverage.

3           “(E) PREDOMINANCE.—For purposes of  
4           this subsection, a treatment limit or financial  
5           requirement with respect to a category of items  
6           and services is considered to be predominant if  
7           it is the most common or frequent of such type  
8           of limit or requirement with respect to such cat-  
9           egory of items and services.

10          “(4) BENEFICIARY FINANCIAL REQUIRE-  
11          MENTS.—In the case of a group health plan that  
12          provides both medical and surgical benefits and  
13          mental health or substance-related disorder bene-  
14          fits—

15                 “(A) NO BENEFICIARY FINANCIAL RE-  
16                 QUIREMENT.—If the plan or coverage does not  
17                 include a beneficiary financial requirement (as  
18                 defined in subparagraph (C)) on substantially  
19                 all medical and surgical benefits within a cat-  
20                 egory of items and services (specified under  
21                 paragraph (3)(C)), the plan or coverage may  
22                 not impose such a beneficiary financial require-  
23                 ment on mental health or substance-related dis-  
24                 order benefits for items and services within  
25                 such category.

1                   “(B) BENEFICIARY FINANCIAL REQUIRE-  
2                   MENT.—

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

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

17                  “(C) BENEFICIARY FINANCIAL REQUIRE-  
18                  MENT DEFINED.—For purposes of this para-  
19                  graph, the term ‘beneficiary financial require-  
20                  ment’ includes, with respect to a plan or cov-  
21                  erage, any deductible, coinsurance, co-payment,  
22                  other cost sharing, and limitation on the total  
23                  amount that may be paid by a participant or  
24                  beneficiary with respect to benefits under the  
25                  plan or coverage, but does not include the appli-

1 cation of any aggregate lifetime limit or annual  
2 limit.”; and

3 (2) in subsection (b)—

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

7 (B) by striking “; or” and inserting a pe-  
8 riod; and

9 (C) by striking paragraph (2).

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

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

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

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

24 “(4) MENTAL HEALTH BENEFITS.—The term  
25 ‘mental health benefits’ means benefits with respect

1 to services for mental health conditions, as defined  
2 under the terms of the plan and in accordance with  
3 applicable law, but does not include substance-re-  
4 lated disorder benefits.

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

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

15 “(5) AVAILABILITY OF PLAN INFORMATION.—  
16 The criteria for medical necessity determinations  
17 made under the plan with respect to mental health  
18 and substance-related disorder benefits (or the  
19 health insurance coverage offered in connection with  
20 the plan with respect to such benefits) shall be made  
21 available by the plan administrator (or the health in-  
22 surance issuer offering such coverage) in accordance  
23 with regulations to any current or potential partici-  
24 pant, beneficiary, or contracting provider upon re-  
25 quest. The reason for any denial under the plan (or

1 coverage) of reimbursement or payment for services  
2 with respect to mental health and substance-related  
3 disorder benefits in the case of any participant or  
4 beneficiary shall, on request or as otherwise re-  
5 quired, be made available by the plan administrator  
6 (or the health insurance issuer offering such cov-  
7 erage) to the participant or beneficiary in accord-  
8 ance with regulations.”.

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

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

14 “(A) MINIMUM SCOPE OF MENTAL  
15 HEALTH AND SUBSTANCE-RELATED DISORDER  
16 BENEFITS.—In the case of a group health plan  
17 (or health insurance coverage offered in connec-  
18 tion with such a plan) that provides any mental  
19 health or substance-related disorder benefits,  
20 the plan or coverage shall include benefits for  
21 any mental health condition or substance-re-  
22 lated disorder included in the most recent edi-  
23 tion of the Diagnostic and Statistical Manual of  
24 Mental Disorders published by the American  
25 Psychiatric Association.

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

3                   “(i) IN GENERAL.—In the case of a  
4                   plan or coverage that provides both med-  
5                   ical and surgical benefits and mental  
6                   health or substance-related disorder bene-  
7                   fits, if medical and surgical benefits are  
8                   provided for substantially all items and  
9                   services in a category specified in clause  
10                  (ii) furnished outside any network of pro-  
11                  viders established or recognized under such  
12                  plan or coverage, the mental health and  
13                  substance-related disorder benefits shall  
14                  also be provided for items and services in  
15                  such category furnished outside any net-  
16                  work of providers established or recognized  
17                  under such plan or coverage in accordance  
18                  with the requirements of this section.

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

1 and all mental health and substance-re-  
2 lated disorder benefits shall be classified  
3 into one of the following categories:

4 “(I) EMERGENCY.—Items and  
5 services, whether furnished on an in-  
6 patient or outpatient basis, required  
7 for the treatment of an emergency  
8 medical condition (as defined in sec-  
9 tion 1867(e) of the Social Security  
10 Act, including an emergency condition  
11 relating to mental health or sub-  
12 stance-related disorders).

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

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

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

22 “(2) INCREASED COST EXEMPTION.—

23 “(A) IN GENERAL.—With respect to a  
24 group health plan (or health insurance coverage  
25 offered in connection with such a plan), if the

1 application of this section to such plan (or cov-  
2 erage) results in an increase for the plan year  
3 involved of the actual total costs of coverage  
4 with respect to medical and surgical benefits  
5 and mental health and substance-related dis-  
6 order benefits under the plan (as determined  
7 and certified under subparagraph (C)) by an  
8 amount that exceeds the applicable percentage  
9 described in subparagraph (B) of the actual  
10 total plan costs, the provisions of this section  
11 shall not apply to such plan (or coverage) dur-  
12 ing the following plan year, and such exemption  
13 shall apply to the plan (or coverage) for 1 plan  
14 year.

15 “(B) APPLICABLE PERCENTAGE.—With re-  
16 spect to a plan (or coverage), the applicable  
17 percentage described in this paragraph shall  
18 be—

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

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

24 “(C) DETERMINATIONS BY ACTUARIES.—  
25 Determinations as to increases in actual costs

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

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

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

1                   “(F) NOTIFICATION OF APPROPRIATE  
2                   AGENCY.—

3                   “(i) IN GENERAL.—A group health  
4                   plan that, based on a certification de-  
5                   scribed under subparagraph (C), qualifies  
6                   for an exemption under this paragraph,  
7                   and elects to implement the exemption,  
8                   shall notify the Department of Labor of  
9                   such election.

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

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

19                   “(II) for both the plan year upon  
20                   which a cost exemption is sought and  
21                   the year prior, a description of the ac-  
22                   tual total costs of coverage with re-  
23                   spect to medical and surgical benefits  
24                   and mental health and substance-re-

1 lated disorder benefits under the plan;  
2 and

3 “(III) for both the plan year  
4 upon which a cost exemption is sought  
5 and the year prior, the actual total  
6 costs of coverage with respect to men-  
7 tal health and substance-related dis-  
8 order benefits under the plan.

9 “(iii) CONFIDENTIALITY.—A notifica-  
10 tion under clause (i) shall be confidential.  
11 The Department of Labor shall make  
12 available, upon request to the appropriate  
13 committees of Congress and on not more  
14 than an annual basis, an anonymous  
15 itemization of such notifications, that in-  
16 cludes—

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

20 “(II) a summary of the data re-  
21 ceived under clause (ii).

22 “(G) NO IMPACT ON APPLICATION OF  
23 STATE LAW.—The fact that a plan or coverage  
24 is exempt from the provisions of this section

1 under subparagraph (A) shall not affect the ap-  
2 plication of State law to such plan or coverage.

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

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

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

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

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

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

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

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

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

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

23          (i) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

7 (j) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendments made by  
9 this section shall apply with respect to plan years be-  
10 ginning on or after January 1, 2009.

11 (2) SPECIAL RULE FOR COLLECTIVE BAR-  
12 GAINING AGREEMENTS.—In the case of a group  
13 health plan maintained pursuant to one or more col-  
14 lective bargaining agreements between employee rep-  
15 resentatives and one or more employers ratified be-  
16 fore the date of the enactment of this Act, the  
17 amendments made by this section shall not apply to  
18 plan years beginning before the later of—

19 (A) the date on which the last of the col-  
20 lective bargaining agreements relating to the  
21 plan terminates (determined without regard to  
22 any extension thereof agreed to after the date  
23 of the enactment of this Act), or

24 (B) January 1, 2009.

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

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

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

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

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

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

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

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

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

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

1           “(B) TREATMENT LIMIT.—If the plan or  
2 coverage includes a treatment limit on substan-  
3 tially all medical and surgical benefits in any  
4 category of items or services, the plan or cov-  
5 erage may not impose such a treatment limit on  
6 mental health or substance-related disorder  
7 benefits for items and services within such cat-  
8 egory that is more restrictive than the predomi-  
9 nant treatment limit that is applicable to med-  
10 ical and surgical benefits for items and services  
11 within such category.

12           “(C) CATEGORIES OF ITEMS AND SERV-  
13 ICES FOR APPLICATION OF TREATMENT LIMITS  
14 AND BENEFICIARY FINANCIAL REQUIRE-  
15 MENTS.—For purposes of this paragraph and  
16 paragraph (4), there shall be the following five  
17 categories of items and services for benefits,  
18 whether medical and surgical benefits or mental  
19 health and substance-related disorder benefits,  
20 and all medical and surgical benefits and all  
21 mental health and substance related benefits  
22 shall be classified into one of the following cat-  
23 egories:

24           “(i) INPATIENT, IN-NETWORK.—Items  
25 and services not described in clause (v)

1 furnished on an inpatient basis and within  
2 a network of providers established or rec-  
3 ognized under such plan or coverage.

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

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

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

21 “(v) EMERGENCY CARE.—Items and  
22 services, whether furnished on an inpatient  
23 or outpatient basis or within or outside  
24 any network of providers, required for the  
25 treatment of an emergency medical condi-

1           tion (as defined in section 1867(e) of the  
2           Social Security Act, including an emer-  
3           gency condition relating to mental health  
4           or substance-related disorders).

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

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

19          “(4) BENEFICIARY FINANCIAL REQUIRE-  
20          MENTS.—In the case of a group health plan that  
21          provides both medical and surgical benefits and  
22          mental health or substance-related disorder bene-  
23          fits—

24          “(A) NO BENEFICIARY FINANCIAL RE-  
25          QUIREMENT.—If the plan or coverage does not

1 include a beneficiary financial requirement (as  
2 defined in subparagraph (C)) on substantially  
3 all medical and surgical benefits within a cat-  
4 egory of items and services (specified in para-  
5 graph (3)(C)), the plan or coverage may not im-  
6 pose such a beneficiary financial requirement on  
7 mental health or substance-related disorder  
8 benefits for items and services within such cat-  
9 egory.

10 “(B) BENEFICIARY FINANCIAL REQUIRE-  
11 MENT.—

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

1 both to medical and surgical benefits with-  
2 in such category and to mental health and  
3 substance-related disorder benefits within  
4 such category and shall not distinguish in  
5 the application of such requirement be-  
6 tween such medical and surgical benefits  
7 and such mental health and substance-re-  
8 lated disorder benefits.

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

1           “(C) BENEFICIARY FINANCIAL REQUIRE-  
2           MENT DEFINED.—For purposes of this para-  
3           graph, the term ‘beneficiary financial require-  
4           ment’ includes, with respect to a plan or cov-  
5           erage, any deductible, coinsurance, co-payment,  
6           other cost sharing, and limitation on the total  
7           amount that may be paid by a participant or  
8           beneficiary with respect to benefits under the  
9           plan or coverage, but does not include the appli-  
10          cation of any aggregate lifetime limit or annual  
11          limit.”; and

12          (2) in subsection (b)—

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

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

18                 (C) by striking paragraph (2).

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

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

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

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

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

14           “(5) SUBSTANCE-RELATED DISORDER BENE-  
15 FITS.—The term ‘substance-related disorder bene-  
16 fits’ means benefits with respect to services for sub-  
17 stance-related disorders, as defined under the terms  
18 of the plan and in accordance with applicable law.”.

19           (c) AVAILABILITY OF PLAN INFORMATION ABOUT  
20 CRITERIA FOR MEDICAL NECESSITY.—Subsection (a) of  
21 such section, as amended by subsection (a)(1), is further  
22 amended by adding at the end the following new para-  
23 graph:

24           “(5) AVAILABILITY OF PLAN INFORMATION.—  
25 The criteria for medical necessity determinations

1       made under the plan with respect to mental health  
2       and substance-related disorder benefits (or the  
3       health insurance coverage offered in connection with  
4       the plan with respect to such benefits) shall be made  
5       available by the plan administrator (or the health in-  
6       surance issuer offering such coverage) in accordance  
7       with regulations to any current or potential partici-  
8       pant, beneficiary, or contracting provider upon re-  
9       quest. The reason for any denial under the plan (or  
10      coverage) of reimbursement or payment for services  
11      with respect to mental health and substance-related  
12      disorder benefits in the case of any participant or  
13      beneficiary shall, on request or as otherwise re-  
14      quired, be made available by the plan administrator  
15      (or the health insurance issuer offering such cov-  
16      erage) to the participant or beneficiary in accord-  
17      ance with regulations.”.

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

21             “(6) MINIMUM SCOPE OF COVERAGE AND EQ-  
22      UNITY IN OUT-OF-NETWORK BENEFITS.—

23             “(A) MINIMUM SCOPE OF MENTAL  
24      HEALTH AND SUBSTANCE-RELATED DISORDER  
25      BENEFITS.—In the case of a group health plan

1 (or health insurance coverage offered in connec-  
2 tion with such a plan) that provides any mental  
3 health or substance-related disorder benefits,  
4 the plan or coverage shall include benefits for  
5 any mental health condition or substance-re-  
6 lated disorder included in the most recent edi-  
7 tion of the Diagnostic and Statistical Manual of  
8 Mental Disorders published by the American  
9 Psychiatric Association.

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

12 “(i) IN GENERAL.—In the case of a  
13 group health plan (or health insurance cov-  
14 erage offered in connection with such a  
15 plan) that provides both medical and sur-  
16 gical benefits and mental health or sub-  
17 stance-related disorder benefits, if medical  
18 and surgical benefits are provided for sub-  
19 stantially all items and services in a cat-  
20 egory specified in clause (ii) furnished out-  
21 side any network of providers established  
22 or recognized under such plan or coverage,  
23 the mental health and substance-related  
24 disorder benefits shall also be provided for  
25 items and services in such category fur-

1                   nished outside any network of providers es-  
2                   tablished or recognized under such plan or  
3                   coverage in accordance with the require-  
4                   ments of this section.

5                   “(ii) CATEGORIES OF ITEMS AND  
6                   SERVICES.—For purposes of clause (i),  
7                   there shall be the following three categories  
8                   of items and services for benefits, whether  
9                   medical and surgical benefits or mental  
10                  health and substance-related disorder bene-  
11                  fits, and all medical and surgical benefits  
12                  and all mental health and substance-re-  
13                  lated disorder benefits shall be classified  
14                  into one of the following categories:

15                  “(I) EMERGENCY.—Items and  
16                  services, whether furnished on an in-  
17                  patient or outpatient basis, required  
18                  for the treatment of an emergency  
19                  medical condition (as defined in sec-  
20                  tion 1867(e) of the Social Security  
21                  Act, including an emergency condition  
22                  relating to mental health or sub-  
23                  stance-related disorders).

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

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

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

10           “(2) INCREASED COST EXEMPTION.—

11                   “(A) IN GENERAL.—With respect to a  
12 group health plan (or health insurance coverage  
13 offered in connection with such a plan), if the  
14 application of this section to such plan (or cov-  
15 erage) results in an increase for the plan year  
16 involved of the actual total costs of coverage  
17 with respect to medical and surgical benefits  
18 and mental health and substance-related dis-  
19 order benefits under the plan (as determined  
20 and certified under subparagraph (C)) by an  
21 amount that exceeds the applicable percentage  
22 described in subparagraph (B) of the actual  
23 total plan costs, the provisions of this section  
24 shall not apply to such plan (or coverage) dur-  
25 ing the following plan year, and such exemption

1 shall apply to the plan (or coverage) for 1 plan  
2 year.

3 “(B) APPLICABLE PERCENTAGE.—With re-  
4 spect to a plan (or coverage), the applicable  
5 percentage described in this paragraph shall  
6 be—

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

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

12 “(C) DETERMINATIONS BY ACTUARIES.—  
13 Determinations as to increases in actual costs  
14 under a plan (or coverage) for purposes of this  
15 subsection shall be made in writing and pre-  
16 pared and certified by a qualified and licensed  
17 actuary who is a member in good standing of  
18 the American Academy of Actuaries. Such de-  
19 terminations shall be made available by the  
20 plan administrator (or health insurance issuer,  
21 as the case may be) to the general public.

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

1           determinations under subparagraph (A) shall be  
2           made after such plan (or coverage) has com-  
3           plied with this section for the first 6 months of  
4           the plan year involved.

5           “(E) NOTIFICATION.—A group health plan  
6           under this part shall comply with the notice re-  
7           quirement under section 712(c)(2)(E) of the  
8           Employee Retirement Income Security Act of  
9           1974 with respect to a modification of mental  
10          health and substance-related disorder benefits  
11          as permitted under this paragraph as if such  
12          section applied to such plan.

13          “(F) NOTIFICATION OF APPROPRIATE  
14          AGENCY.—

15                 “(i) IN GENERAL.—A group health  
16                 plan that, based on a certification de-  
17                 scribed under subparagraph (C), qualifies  
18                 for an exemption under this paragraph,  
19                 and elects to implement the exemption,  
20                 shall notify the Secretary of Health and  
21                 Human Services of such election.

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

24                         “(I) a description of the number  
25                         of covered lives under the plan (or

1 coverage) involved at the time of the  
2 notification, and as applicable, at the  
3 time of any prior election of the cost-  
4 exemption under this paragraph by  
5 such plan (or coverage);

6 “(II) for both the plan year upon  
7 which a cost exemption is sought and  
8 the year prior, a description of the ac-  
9 tual total costs of coverage with re-  
10 spect to medical and surgical benefits  
11 and mental health and substance-re-  
12 lated disorder benefits under the plan;  
13 and

14 “(III) for both the plan year  
15 upon which a cost exemption is sought  
16 and the year prior, the actual total  
17 costs of coverage with respect to men-  
18 tal health and substance-related dis-  
19 order benefits under the plan.

20 “(iii) CONFIDENTIALITY.—A notifica-  
21 tion under clause (i) shall be confidential.  
22 The Secretary of Health and Human Serv-  
23 ices shall make available, upon request to  
24 the appropriate committees of Congress  
25 and on not more than an annual basis, an

1 anonymous itemization of such notifica-  
2 tions, that includes—

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

6 “(II) a summary of the data re-  
7 ceived under clause (ii).

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

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

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

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

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

1 (h) CLARIFICATION REGARDING PREEMPTION.—

2 Such section is further amended by inserting after sub-  
3 section (e) the following new subsection:

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

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

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

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

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

19 (j) EFFECTIVE DATE.—

20 (1) IN GENERAL.—Except as otherwise pro-  
21 vided in this subsection, the amendments made by  
22 this section shall apply with respect to plan years be-  
23 ginning on or after January 1, 2009.

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

4           (3) SPECIAL RULE FOR COLLECTIVE BAR-  
5           GAINING AGREEMENTS.—In the case of a group  
6           health plan maintained pursuant to one or more col-  
7           lective bargaining agreements between employee rep-  
8           resentatives and one or more employers ratified be-  
9           fore the date of the enactment of this Act, the  
10          amendments made by this section shall not apply to  
11          plan years beginning before the later of—

12                   (A) the date on which the last of the col-  
13                   lective bargaining agreements relating to the  
14                   plan terminates (determined without regard to  
15                   any extension thereof agreed to after the date  
16                   of the enactment of this Act), or

17                   (B) January 1, 2009.

18          For purposes of subparagraph (A), any plan amend-  
19          ment made pursuant to a collective bargaining  
20          agreement relating to the plan which amends the  
21          plan solely to conform to any requirement added by  
22          this section shall not be treated as a termination of  
23          such collective bargaining agreement.

1 **SEC. 4. AMENDMENTS TO THE INTERNAL REVENUE CODE**  
2 **OF 1986.**

3 (a) **EXTENSION OF PARITY TO TREATMENT LIMITS**  
4 **AND BENEFICIARY FINANCIAL REQUIREMENTS.**—Section  
5 9812 of the Internal Revenue Code of 1986 is amended—

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

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

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

21 “(B) **TREATMENT LIMIT.**—If the plan in-  
22 cludes a treatment limit on substantially all  
23 medical and surgical benefits in any category of  
24 items or services, the plan may not impose such  
25 a treatment limit on mental health or sub-  
26 stance-related disorder benefits for items and

1 services within such category that is more re-  
2 strictive than the predominant treatment limit  
3 that is applicable to medical and surgical bene-  
4 fits for items and services within such category.

5 “(C) CATEGORIES OF ITEMS AND SERV-  
6 ICES FOR APPLICATION OF TREATMENT LIMITS  
7 AND BENEFICIARY FINANCIAL REQUIRE-  
8 MENTS.—For purposes of this paragraph and  
9 paragraph (4), there shall be the following five  
10 categories of items and services for benefits,  
11 whether medical and surgical benefits or mental  
12 health and substance-related disorder benefits,  
13 and all medical and surgical benefits and all  
14 mental health and substance related benefits  
15 shall be classified into one of the following cat-  
16 egories:

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

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

1 outside any network of providers estab-  
2 lished or recognized under such plan.

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

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

13 “(v) EMERGENCY CARE.—Items and  
14 services, whether furnished on an inpatient  
15 or outpatient basis or within or outside  
16 any network of providers, required for the  
17 treatment of an emergency medical condi-  
18 tion (as defined in section 1867(e) of the  
19 Social Security Act, including an emer-  
20 gency condition relating to mental health  
21 or substance-related disorders).

22 “(D) TREATMENT LIMIT DEFINED.—For  
23 purposes of this paragraph, the term ‘treatment  
24 limit’ means, with respect to a plan, limitation  
25 on the frequency of treatment, number of visits

1 or days of coverage, or other similar limit on  
2 the duration or scope of treatment under the  
3 plan.

4 “(E) PREDOMINANCE.—For purposes of  
5 this subsection, a treatment limit or financial  
6 requirement with respect to a category of items  
7 and services is considered to be predominant if  
8 it is the most common or frequent of such type  
9 of limit or requirement with respect to such cat-  
10 egory of items and services.

11 “(4) BENEFICIARY FINANCIAL REQUIRE-  
12 MENTS.—In the case of a group health plan that  
13 provides both medical and surgical benefits and  
14 mental health or substance-related disorder bene-  
15 fits—

16 “(A) NO BENEFICIARY FINANCIAL RE-  
17 QUIREMENT.—If the plan does not include a  
18 beneficiary financial requirement (as defined in  
19 subparagraph (C)) on substantially all medical  
20 and surgical benefits within a category of items  
21 and services (specified in paragraph (3)(C)),  
22 the plan may not impose such a beneficiary fi-  
23 nancial requirement on mental health or sub-  
24 stance-related disorder benefits for items and  
25 services within such category.

1                   “(B) BENEFICIARY FINANCIAL REQUIRE-  
2                   MENT.—

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

1                   “(ii) OTHER FINANCIAL REQUIRE-  
2                   MENTS.—If the plan includes a beneficiary  
3                   financial requirement not described in  
4                   clause (i) on substantially all medical and  
5                   surgical benefits within a category of items  
6                   and services, the plan may not impose such  
7                   financial requirement on mental health or  
8                   substance-related disorder benefits for  
9                   items and services within such category in  
10                  a way that results in greater out-of-pocket  
11                  expenses to the participant or beneficiary  
12                  than the predominant beneficiary financial  
13                  requirement applicable to medical and sur-  
14                  gical benefits for items and services within  
15                  such category.

16                  “(C) BENEFICIARY FINANCIAL REQUIRE-  
17                  MENT DEFINED.—For purposes of this para-  
18                  graph, the term ‘beneficiary financial require-  
19                  ment’ includes, with respect to a plan, any de-  
20                  ductible, coinsurance, co-payment, other cost  
21                  sharing, and limitation on the total amount  
22                  that may be paid by a participant or beneficiary  
23                  with respect to benefits under the plan, but  
24                  does not include the application of any aggre-  
25                  gate lifetime limit or annual limit.”, and

1 (2) in subsection (b)—

2 (A) by striking “construed—” and all that  
3 follows through “(1) as requiring” and insert-  
4 ing “construed as requiring”,

5 (B) by striking “; or” and inserting a pe-  
6 riod, and

7 (C) by striking paragraph (2).

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

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

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

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

22 “(4) MENTAL HEALTH BENEFITS.—The term  
23 ‘mental health benefits’ means benefits with respect  
24 to services for mental health conditions, as defined  
25 under the terms of the plan and in accordance with

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

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

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

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

1 available by the plan administrator to the partici-  
2 pant or beneficiary in accordance with regulations.”.

3 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-  
4 section (a) of section 9812 of such Code is further amend-  
5 ed by adding at the end the following new paragraph:

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

8 “(A) MINIMUM SCOPE OF MENTAL  
9 HEALTH AND SUBSTANCE-RELATED DISORDER  
10 BENEFITS.—In the case of a group health plan  
11 that provides any mental health or substance-  
12 related disorder benefits, the plan shall include  
13 benefits for any mental health condition or sub-  
14 stance-related disorder included in the most re-  
15 cent edition of the Diagnostic and Statistical  
16 Manual of Mental Disorders published by the  
17 American Psychiatric Association.

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

20 “(i) IN GENERAL.—In the case of a  
21 group health plan that provides both med-  
22 ical and surgical benefits and mental  
23 health or substance-related disorder bene-  
24 fits, if medical and surgical benefits are  
25 provided for substantially all items and

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

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

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

1                   tion 1867(e) of the Social Security  
2                   Act, including an emergency condition  
3                   relating to mental health or sub-  
4                   stance-related disorders).

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

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

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

14               “(2) INCREASED COST EXEMPTION.—

15                       “(A) IN GENERAL.—With respect to a  
16                       group health plan, if the application of this sec-  
17                       tion to such plan results in an increase for the  
18                       plan year involved of the actual total costs of  
19                       coverage with respect to medical and surgical  
20                       benefits and mental health and substance-re-  
21                       lated disorder benefits under the plan (as deter-  
22                       mined and certified under subparagraph (C)) by  
23                       an amount that exceeds the applicable percent-  
24                       age described in subparagraph (B) of the actual  
25                       total plan costs, the provisions of this section

1 shall not apply to such plan during the fol-  
2 lowing plan year, and such exemption shall  
3 apply to the plan for 1 plan year.

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

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

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

12 “(C) DETERMINATIONS BY ACTUARIES.—  
13 Determinations as to increases in actual costs  
14 under a plan for purposes of this subsection  
15 shall be made in writing and prepared and cer-  
16 tified by a qualified and licensed actuary who is  
17 a member in good standing of the American  
18 Academy of Actuaries. Such determinations  
19 shall be made available by the plan adminis-  
20 trator to the general public.

21 “(D) 6-MONTH DETERMINATIONS.—If a  
22 group health plan seeks an exemption under  
23 this paragraph, determinations under subpara-  
24 graph (A) shall be made after such plan has

1           complied with this section for the first 6  
2           months of the plan year involved.

3           “(E) NOTIFICATION OF APPROPRIATE  
4           AGENCY.—

5           “(i) IN GENERAL.—A group health  
6           plan that, based on a certification de-  
7           scribed under subparagraph (C), qualifies  
8           for an exemption under this paragraph,  
9           and elects to implement the exemption,  
10          shall notify the Secretary of the Treasury  
11          of such election.

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

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

21                 “(II) for both the plan year upon  
22                 which a cost exemption is sought and  
23                 the year prior, a description of the ac-  
24                 tual total costs of coverage with re-  
25                 spect to medical and surgical benefits

1 and mental health and substance-re-  
2 lated disorder benefits under the plan;  
3 and

4 “(III) for both the plan year  
5 upon which a cost exemption is sought  
6 and the year prior, the actual total  
7 costs of coverage with respect to men-  
8 tal health and substance-related dis-  
9 order benefits under the plan.

10 “(iii) CONFIDENTIALITY.—A notifica-  
11 tion under clause (i) shall be confidential.  
12 The Secretary of the Treasury shall make  
13 available, upon request to the appropriate  
14 committees of Congress and on not more  
15 than an annual basis, an anonymous  
16 itemization of such notifications, that in-  
17 cludes—

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

21 “(II) a summary of the data re-  
22 ceived under clause (ii).

23 “(F) CONSTRUCTION.—Nothing in this  
24 paragraph shall be construed as preventing a  
25 group health plan from complying with the pro-

1           visions of this section notwithstanding that the  
2           plan is not required to comply with such provi-  
3           sions due to the application of subparagraph  
4           (A).”.

5           (f) CHANGE IN EXCLUSION FOR SMALLEST EMPLOY-  
6           ERS.—Paragraph (1) of section 9812(c) of such Code is  
7           amended to read as follows:

8           “(1) SMALL EMPLOYER EXEMPTION.—

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

12          “(B) SMALL EMPLOYER.—For purposes of  
13          subparagraph (A), the term ‘small employer’  
14          means, with respect to a calendar year and a  
15          plan year, an employer who employed an aver-  
16          age of at least 2 (or 1 in the case of an em-  
17          ployer residing in a State that permits small  
18          groups to include a single individual) but not  
19          more than 50 employees on business days dur-  
20          ing the preceding calendar year. For purposes  
21          of the preceding sentence, all persons treated as  
22          a single employer under subsection (b), (c),  
23          (m), or (o) of section 414 shall be treated as 1  
24          employer and rules similar to rules of subpara-

1           graphs (B) and (C) of section 4980D(d)(2)  
2           shall apply.”.

3           (g) ELIMINATION OF SUNSET PROVISION.—Section  
4 9812 of such Code is amended by striking subsection (f).

5           (h) CONFORMING AMENDMENTS TO HEADING.—

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

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

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

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

14           (i) EFFECTIVE DATE.—

15           (1) IN GENERAL.—Except as otherwise pro-  
16 vided in this subsection, the amendments made by  
17 this section shall apply with respect to plan years be-  
18 ginning on or after January 1, 2009.

19           (2) ELIMINATION OF SUNSET.—The amend-  
20 ment made by subsection (g) shall apply to benefits  
21 for services furnished after December 31, 2007.

22           (3) SPECIAL RULE FOR COLLECTIVE BAR-  
23 GAINING AGREEMENTS.—In the case of a group  
24 health plan maintained pursuant to one or more col-  
25 lective bargaining agreements between employee rep-

1        representatives and one or more employers ratified be-  
2        fore the date of the enactment of this Act, the  
3        amendments made by this section (other than sub-  
4        section (g)) shall not apply to plan years beginning  
5        before the later of—

6                    (A) the date on which the last of the col-  
7                    lective bargaining agreements relating to the  
8                    plan terminates (determined without regard to  
9                    any extension thereof agreed to after the date  
10                   of the enactment of this Act), or

11                   (B) January 1, 2009.

12        For purposes of subparagraph (A), any plan amend-  
13        ment made pursuant to a collective bargaining  
14        agreement relating to the plan which amends the  
15        plan solely to conform to any requirement added by  
16        this section shall not be treated as a termination of  
17        such collective bargaining agreement.

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

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

21                    (1) by striking “and” at the end of subclause  
22                    (IV);

23                    (2) in subclause (V)—

1 (A) by inserting “and before January 1,  
2 2009, and after December 31, 2014,” after  
3 “December 31, 1995,”; and

4 (B) by striking the period at the end and  
5 inserting “; and”; and

6 (3) by adding at the end the following new sub-  
7 clause:

8 “(VI) after December 31, 2008,  
9 and before January 1, 2015, is 20.1  
10 percent.”.

11 **SEC. 6. LIMITATION ON MEDICARE EXCEPTION TO THE**  
12 **PROHIBITION ON CERTAIN PHYSICIAN RE-**  
13 **FERRALS FOR HOSPITALS.**

14 (a) **IN GENERAL.**—Section 1877 of the Social Secu-  
15 rity Act (42 U.S.C. 1395nn) is amended—

16 (1) in subsection (d)(2)—

17 (A) in subparagraph (A), by striking  
18 “and” at the end;

19 (B) in subparagraph (B), by striking the  
20 period at the end and inserting “; and”; and

21 (C) by adding at the end the following new  
22 subparagraph:

23 “(C) in the case where the entity is a hos-  
24 pital, the hospital meets the requirements of  
25 paragraph (3)(D).”;

1 (2) in subsection (d)(3)—

2 (A) in subparagraph (B), by striking  
3 “and” at the end;

4 (B) in subparagraph (C), by striking the  
5 period at the end and inserting “; and”; and

6 (C) by adding at the end the following new  
7 subparagraph:

8 “(D) the hospital meets the requirements  
9 described in subsection (i)(1) not later than 18  
10 months after the date of the enactment of this  
11 subparagraph.”; and

12 (3) by adding at the end the following new sub-  
13 section:

14 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY  
15 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-  
16 MENT PROHIBITION.—

17 “(1) REQUIREMENTS DESCRIBED.—For pur-  
18 poses of subsection (d)(3)(D), the requirements de-  
19 scribed in this paragraph for a hospital are as fol-  
20 lows:

21 “(A) PROVIDER AGREEMENT.—The hos-  
22 pital had—

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

1                   “(ii) a provider agreement under sec-  
2                   tion 1866 in effect on such date of enact-  
3                   ment.

4                   “(B) LIMITATION ON EXPANSION OF FA-  
5                   CILITY CAPACITY.—Except as provided in para-  
6                   graph (3), the number of operating rooms and  
7                   beds of the hospital at any time on or after the  
8                   date of the enactment of this subsection are no  
9                   greater than the number of operating rooms  
10                  and beds as of such date.

11                  “(C) PREVENTING CONFLICTS OF INTER-  
12                  EST.—

13                  “(i) The hospital submits to the Sec-  
14                  retary an annual report containing a de-  
15                  tailed description of—

16                         “(I) the identity of each physi-  
17                         cian owner and any other owners of  
18                         the hospital; and

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

21                         “(ii) The hospital has procedures in  
22                         place to require that any referring physi-  
23                         cian owner discloses to the patient being  
24                         referred, by a time that permits the pa-  
25                         tient to make a meaningful decision re-

1                   garding the receipt of care, as determined  
2                   by the Secretary—

3                   “(I) the ownership interest of  
4                   such referring physician in the hos-  
5                   pital; and

6                   “(II) if applicable, any such own-  
7                   ership interest of the treating physi-  
8                   cian.

9                   “(iii) The hospital does not condition  
10                  any physician ownership interests either di-  
11                  rectly or indirectly on the physician owner  
12                  making or influencing referrals to the hos-  
13                  pital or otherwise generating business for  
14                  the hospital.

15                  “(iv) The hospital discloses the fact  
16                  that the hospital is partially owned by phy-  
17                  sicians—

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

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

22                  “(D) ENSURING BONA FIDE INVEST-  
23                  MENT.—

24                  “(i) Physician owners in the aggregate  
25                  do not own more than 40 percent of the

1 total value of the investment interests held  
2 in the hospital or in an entity whose assets  
3 include the hospital.

4 “(ii) The investment interest of any  
5 individual physician owner does not exceed  
6 2 percent of the total value of the invest-  
7 ment interests held in the hospital or in an  
8 entity whose assets include the hospital.

9 “(iii) Any ownership or investment in-  
10 terests that the hospital offers to a physi-  
11 cian owner are not offered on more favor-  
12 able terms than the terms offered to a per-  
13 son who is not a physician owner.

14 “(iv) The hospital (or any investors in  
15 the hospital) does not directly or indirectly  
16 provide loans or financing for any physi-  
17 cian owner investments in the hospital.

18 “(v) The hospital (or any investors in  
19 the hospital) does not directly or indirectly  
20 guarantee a loan, make a payment toward  
21 a loan, or otherwise subsidize a loan, for  
22 any individual physician owner or group of  
23 physician owners that is related to acquir-  
24 ing any ownership interest in the hospital.

1                   “(vi) Investment returns are distrib-  
2                   uted to each investor in the hospital in an  
3                   amount that is directly proportional to the  
4                   investment of capital by such investor in  
5                   the hospital.

6                   “(vii) Physician owners do not receive,  
7                   directly or indirectly, any guaranteed re-  
8                   ceipt of or right to purchase other business  
9                   interests related to the hospital, including  
10                  the purchase or lease of any property  
11                  under the control of other investors in the  
12                  hospital or located near the premises of the  
13                  hospital.

14                  “(viii) The hospital does not offer a  
15                  physician owner the opportunity to pur-  
16                  chase or lease any property under the con-  
17                  trol of the hospital or any other investor in  
18                  the hospital on more favorable terms than  
19                  the terms offered to an individual who is  
20                  not a physician owner.

21                  “(E) PATIENT SAFETY.—

22                  “(i) Insofar as the hospital admits a  
23                  patient and does not have any physician  
24                  available on the premises to provide serv-  
25                  ices during all hours in which the hospital

1 is providing services to such patient, before  
2 admitting the patient—

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

5 “(II) following such disclosure,  
6 the hospital receives from the patient  
7 a signed acknowledgment that the pa-  
8 tient understands such fact.

9 “(ii) The hospital has the capacity  
10 to—

11 “(I) provide assessment and ini-  
12 tial treatment for patients; and

13 “(II) refer and transfer patients  
14 to hospitals with the capability to  
15 treat the needs of the patient in-  
16 volved.

17 “(2) PUBLICATION OF INFORMATION RE-  
18 PORTED.—The Secretary shall publish, and update  
19 on an annual basis, the information submitted by  
20 hospitals under paragraph (1)(C)(i) on the public  
21 Internet website of the Centers for Medicare & Med-  
22 icaid Services.

23 “(3) EXCEPTION TO PROHIBITION ON EXPAN-  
24 SION OF FACILITY CAPACITY.—

25 “(A) PROCESS.—

1                   “(i) ESTABLISHMENT.—The Secretary  
2                   shall establish and implement a process  
3                   under which an applicable hospital (as de-  
4                   fined in subparagraph (E)) may apply for  
5                   an exception from the requirement under  
6                   paragraph (1)(B).

7                   “(ii) OPPORTUNITY FOR COMMUNITY  
8                   INPUT.—The process under clause (i) shall  
9                   provide individuals and entities in the com-  
10                  munity that the applicable hospital apply-  
11                  ing for an exception is located with the op-  
12                  portunity to provide input with respect to  
13                  the application.

14                  “(iii) TIMING FOR IMPLEMENTA-  
15                  TION.—The Secretary shall implement the  
16                  process under clause (i) on the date that is  
17                  18 months after the date of enactment of  
18                  this subsection.

19                  “(iv) REGULATIONS.—Not later than  
20                  the date that is 18 months after the date  
21                  of enactment of this subsection, the Sec-  
22                  retary shall promulgate regulations to  
23                  carry out the process under clause (i).

24                  “(B) FREQUENCY.—The process described  
25                  in subparagraph (A) shall permit an applicable

1 hospital to apply for an exception up to once  
2 every 2 years.

3 “(C) PERMITTED INCREASE.—

4 “(i) IN GENERAL.—Subject to clause  
5 (ii) and subparagraph (D), an applicable  
6 hospital granted an exception under the  
7 process described in subparagraph (A) may  
8 increase the number of operating rooms  
9 and beds of the applicable hospital above  
10 the baseline number of operating rooms  
11 and beds of the applicable hospital (or, if  
12 the applicable hospital has been granted a  
13 previous exception under this paragraph,  
14 above the number of operating rooms and  
15 beds of the hospital after the application of  
16 the most recent increase under such an ex-  
17 ception) by an amount determined appro-  
18 priate by the Secretary.

19 “(ii) LIFETIME 50 PERCENT INCREASE  
20 LIMITATION.—The Secretary shall not per-  
21 mit an increase in the number of operating  
22 rooms and beds of an applicable hospital  
23 under clause (i) to the extent such increase  
24 would result in the number of operating  
25 rooms and beds of the applicable hospital

1           exceeding 150 percent of the baseline num-  
2           ber of operating rooms and beds of the ap-  
3           plicable hospital.

4           “(iii) BASELINE NUMBER OF OPER-  
5           ATING ROOMS AND BEDS.—In this para-  
6           graph, the term ‘baseline number of oper-  
7           ating rooms and beds’ means the number  
8           of operating rooms and beds of the appli-  
9           cable hospital as of the date of enactment  
10          of this subsection.

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

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

20                 “(i) that is located in a county in  
21                 which the percentage increase in the popu-  
22                 lation during the most recent 5-year period  
23                 (as of the date of the application under  
24                 subparagraph (A)) is at least 200 percent  
25                 of the percentage increase in the popu-

1           lation growth of the United States during  
2           that period, as estimated by Bureau of the  
3           Census;

4           “(ii) whose annual percent of total in-  
5           patient admissions and outpatient visits  
6           that represent inpatient admissions and  
7           outpatient visits under the program under  
8           title XIX is equal to or greater than the  
9           average percent with respect to such ad-  
10          missions and visits for all hospitals located  
11          in the State;

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

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

21          “(v) in the case of a hospital lo-  
22          cated—

23                  “(I) in a core-based statistical  
24                  area, that is located in such an area  
25                  in which the average bed occupancy

1 rate in such area is greater than 80  
2 percent; or

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

7 “(F) PUBLICATION OF FINAL DECI-  
8 SIONS.—The Secretary shall publish final deci-  
9 sions with respect to applications under this  
10 paragraph in the Federal Register.

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

16 “(4) COLLECTION OF OWNERSHIP AND INVEST-  
17 MENT INFORMATION.—For purposes of clauses (i)  
18 and (ii) of paragraph (1)(D), the Secretary shall col-  
19 lect physician ownership and investment information  
20 for each hospital as it existed on the date of the en-  
21 actment of this subsection.

22 “(5) PHYSICIAN OWNER DEFINED.—For pur-  
23 poses of this subsection, the term ‘physician owner’  
24 means a physician (or an immediate family member

1 of such physician) with a direct or an indirect own-  
2 ership interest in the hospital.”.

3 (b) ENFORCEMENT.—

4 (1) ENSURING COMPLIANCE.—The Secretary of  
5 Health and Human Services shall establish policies  
6 and procedures to ensure compliance with the re-  
7 quirements described in subsection (i)(1) of section  
8 1877 of the Social Security Act, as added by sub-  
9 section (a)(3), beginning on the date such require-  
10 ments first apply. Such policies and procedures may  
11 include unannounced site reviews of hospitals.

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

17 (c) ADJUSTMENT TO PAQI FUND.—Section  
18 1848(l)(2)(A)(i)(III) of the Social Security Act (42 U.S.C.  
19 1395w-4(l)(2)(A)(i)(III)), as amended by section  
20 101(a)(2) of the Medicare, Medicaid, and SCHIP Exten-  
21 sion Act of 2007 (Public Law 110-173), is amended by  
22 striking “\$4,960,000,000” and inserting  
23 “\$5,120,000,000”.

24 **SEC. 7. STUDIES AND REPORTS.**

25 (a) IMPLEMENTATION OF ACT.—

1           (1) GAO STUDY.—The Comptroller General of  
2 the United States shall conduct a study that evalu-  
3 ates the effect of the implementation of the amend-  
4 ments made by this Act on—

5                   (A) the cost of health insurance coverage;

6                   (B) access to health insurance coverage  
7                   (including the availability of in-network pro-  
8                   viders);

9                   (C) the quality of health care;

10                  (D) Medicare, Medicaid, and State and  
11                  local mental health and substance abuse treat-  
12                  ment spending;

13                  (E) the number of individuals with private  
14                  insurance who received publicly funded health  
15                  care for mental health and substance-related  
16                  disorders;

17                  (F) spending on public services, such as  
18                  the criminal justice system, special education,  
19                  and income assistance programs;

20                  (G) the use of medical management of  
21                  mental health and substance-related disorder  
22                  benefits and medical necessity determinations  
23                  by group health plans (and health insurance  
24                  issuers offering health insurance coverage in  
25                  connection with such plans) and timely access

1 by participants and beneficiaries to clinically-in-  
2 dicated care for mental health and substance-  
3 use disorders; and

4 (H) other matters as determined appro-  
5 priate by the Comptroller General.

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

11 (b) GAO REPORT ON UNIFORM PATIENT PLACE-  
12 MENT CRITERIA.—Not later than 18 months after the  
13 date of the enactment of this Act, the Comptroller General  
14 shall submit to each House of the Congress a report on  
15 availability of uniform patient placement criteria for men-  
16 tal health and substance-related disorders that could be  
17 used by group health plans and health insurance issuers  
18 to guide determinations of medical necessity and the ex-  
19 tent to which health plans utilize such criteria. If such  
20 criteria do not exist, the report shall include recommenda-  
21 tions on a process for developing such criteria.

22 (c) DOL BIENNIAL REPORT ON ANY OBSTACLES IN  
23 OBTAINING COVERAGE.—Every two years, the Secretary  
24 of Labor, in consultation with the Secretaries of Health  
25 and Human Services and the Treasury, shall submit to

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