

AMENDMENT TO H.R. 1424
OFFERED BY MR. PALLONE

Amend section 3 to read as follows:

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

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

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

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

9 “(3) TREATMENT LIMITS.—

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

21 “(A) NO BENEFICIARY FINANCIAL RE-
22 QUIREMENT.—If the plan or coverage does not
23 include a beneficiary financial requirement (as
24 defined in subparagraph (C)) on substantially
25 all medical and surgical benefits within a cat-

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

7 “(B) BENEFICIARY FINANCIAL REQUIRE-
8 MENT.—

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

1 such category and shall not distinguish in
2 the application of such requirement be-
3 tween such medical and surgical benefits
4 and such mental health and substance-re-
5 lated disorder benefits.

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

21 “(C) BENEFICIARY FINANCIAL REQUIRE-
22 MENT DEFINED.—For purposes of this para-
23 graph, the term ‘beneficiary financial require-
24 ment’ includes, with respect to a plan or cov-
25 erage, any deductible, coinsurance, co-payment,

1 other cost sharing, and limitation on the total
2 amount that may be paid by a participant or
3 beneficiary with respect to benefits under the
4 plan or coverage, but does not include the appli-
5 cation of any aggregate lifetime limit or annual
6 limit.”; and

7 (2) in subsection (b)—

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

11 (B) by striking “; or” and inserting a pe-
12 riod; and

13 (C) by striking paragraph (2).

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

17 (1) by striking “mental health benefits” and in-
18 serting “mental health or substance-related disorder
19 benefits” each place it appears; and

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

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

24 (B) by striking “benefits with respect to
25 mental health services” and inserting “benefits

1 with respect to services for mental health condi-
2 tions or substance-related disorders”; and

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

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

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

1 (or the health insurance issuer offering such cov-
2 erage) to the participant or beneficiary.”.

3 (d) MINIMUM BENEFIT REQUIREMENTS.—Sub-
4 section (a) of such section is further amended by adding
5 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 (or health insurance coverage offered in connec-
12 tion with such a plan) that provides any mental
13 health or substance-related disorder benefits,
14 the plan or coverage shall include benefits for
15 any mental health condition or substance-re-
16 lated disorder included in the most recent edi-
17 tion of the Diagnostic and Statistical Manual of
18 Mental Disorders published by the American
19 Psychiatric Association.

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

22 “(i) IN GENERAL.—In the case of a
23 group health plan (or health insurance cov-
24 erage offered in connection with such a
25 plan) that provides both medical and sur-

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

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

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

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

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

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

17 “(2) INCREASED COST EXEMPTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (j) EFFECTIVE DATE.—

24 (1) IN GENERAL.—Except as otherwise pro-
25 vided in this subsection, the amendments made by

1 this section shall apply with respect to plan years be-
2 ginning on or after January 1, 2008.

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

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

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

19 (B) January 1, 2010.

20 For purposes of subparagraph (A), any plan amend-
21 ment made pursuant to a collective bargaining
22 agreement relating to the plan which amends the
23 plan solely to conform to any requirement imposed
24 under an amendment under this section shall not be

1 treated as a termination of such collective bar-
2 gaining agreement.

3 (k) CONSTRUCTION REGARDING USE OF MEDICAL
4 MANAGEMENT TOOLS.—Nothing in this Act shall be con-
5 strued to prohibit a group health plan or health insurance
6 issuer from using medical management tools as long as
7 such management tools are based on valid medical evi-
8 dence and are relevant to the patient whose medical treat-
9 ment is under review.