AMENDMENT TO H.R. 1424

OFFERED BY MR. PALLONE

Amend section 3 to read as follows:

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

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

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

''(3) TREATMENT LIMITS.—

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

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

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

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

furnished on an inpatient basis and within a network of providers established or recognized under such plan or coverage.

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

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

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

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

tion (as defined in section 1867(e) of the Social Security Act, including an emergency condition relating to mental health and substance-related disorders).

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

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

''(4) BENEFICIARY FINANCIAL REQUIREMENTS.—

''(A) NO BENEFICIARY FINANCIAL REQUIREMENT.—If the plan or coverage does not include a beneficiary financial requirement (as defined in subparagraph (C)) on substantially all medical and surgical benefits within a cat-

egory of items and services (specified in paragraph (3)(C)), the plan or coverage may not impose such a beneficiary financial requirement on mental health or substance-related disorder benefits for items and services within such category.

''(B) BENEFICIARY FINANCIAL REQUIREMENT.—

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

such category and shall not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

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

''(C) BENEFICIARY FINANCIAL REQUIREMENT DEFINED.—For purposes of this paragraph, the term 'beneficiary financial requirement' includes, with respect to a plan or coverage, any deductible, coinsurance, co-payment,

other cost sharing, and limitation on the total amount that may be paid by a participant or beneficiary with respect to benefits under the plan or coverage, but does not include the application of any aggregate lifetime limit or annual limit.''; and

(2) in subsection (b)—

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

(B) by striking ''; or'' and inserting a period; and

(C) by striking paragraph (2).

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

(1) by striking ''mental health benefits'' and inserting ''mental health or substance-related disorder benefits'' each place it appears; and

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

(A) by striking ''MENTAL HEALTH BENEFITS'' and inserting ''MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS'';

(B) by striking ''benefits with respect to mental health services'' and inserting ''benefits

with respect to services for mental health conditions or substance-related disorders''; and

(C) by striking '', but does not include benefits with respect to treatment of substances abuse or chemical dependency''.

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

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

(or the health insurance issuer offering such coverage) to the participant or beneficiary.''.

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

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

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

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

''(i) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and sur-

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

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

"(I) EMERGENCY.—Items and services, whether furnished on an inpatient or outpatient basis, required for the treatment of an emergency medical condition (including an emergency condition relating to mental health or substance-related disorders).

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

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

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

"(2) INCREASED COST EXEMPTION.—

"(A) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance-related dis-

order benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year.

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

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

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

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

actuary and be made available to the general public.

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

''(E) NOTIFICATION.—A group health plan under this part shall comply with the notice requirement under section 712(c)(2)(E) of the Employee Retirement Income Security Act of 1974 with respect to a modification of mental health and substance-related disorder benefits as permitted under this paragraph as if such section applied to such plan.''.

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

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

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

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

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

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

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

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

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

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

(j) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by

this section shall apply with respect to plan years beginning on or after January 1, 2008.

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

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

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

(B) January 1, 2010.

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

treated as a termination of such collective bargaining agreement.

(k) CONSTRUCTION REGARDING USE OF MEDICAL MANAGEMENT TOOLS.—Nothing in this Act shall be construed to prohibit a group health plan or health insurance issuer from using medical management tools as long as such management tools are based on valid medical evidence and are relevant to the patient whose medical treatment is under review.