DESCRIPTION OF THE CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUE TO THE REVENUE PROVISIONS OF H.R. 1424, THE "PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007"

Scheduled for Markup
By the
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
on September 19, 2007

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The House Committee on Ways and Means Subcommittee on Health has scheduled a markup on September 19, 2007, relating to H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007". This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the Chairman's amendment in the nature of a substitute to the revenue provisions of H.R. 1424.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of the Chairman's Amendment in the Nature of a Substitute to the Revenue Provisions of H.R. 1424, the "Paul Wellstone Mental Health and Addiction Equity Act of 2007"* (JCX-81-07), September 18, 2007.

A. Expansion of Mental Health Parity Requirements (sec. 9812 of the Code)

Present Law

The Code, the Employee Retirement Income Security Act of 1974 ("ERISA") and the Public Health Service Act ("PHSA") contain provisions under which group health plans that provide both medical and surgical benefits and mental health benefits cannot impose aggregate lifetime or annual dollar limits on mental health benefits that are not imposed on substantially all medical and surgical benefits ("mental health parity requirements"). In the case of a group health plan which provides benefits for mental health, the mental health parity requirements do not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan, except as specifically provided in regard to parity in the imposition of aggregate lifetime limits and annual limits.

The Code imposes an excise tax on group health plans which fail to meet the mental health parity requirements. The excise tax is equal to $100 per day during the period of noncompliance and is generally imposed on the employer sponsoring the plan if the plan fails to meet the requirements. In the case of violations which are not corrected before the date a notice of examination is sent to the employer and which occurred or continued during the period under examination, the excise tax cannot be less than the lesser of $2,500 or the amount of tax imposed under the general rule. In the case that violations are more than de minimis, the tax cannot be less than the lesser of $15,000 or the amount imposed under the general rule. The maximum tax that can be imposed during a taxable year cannot exceed the lesser of 10 percent of the employer's group health plan expenses for the prior year or $500,000. No tax is imposed if the Secretary determines that the employer did not know, and in exercising reasonable diligence would not have known, that the failure existed.

The mental health parity requirements do not apply to group health plans of small employers. A small employer generally includes an employer who employs at least two, but no more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.[2] The mental parity requirements also do not apply if their application results in an increase in the cost under a group health plan of at least one percent. Further, the mental health parity requirements do not require group health plans to provide mental health benefits.

The Code, ERISA and PHSA mental health parity requirements are scheduled to expire with respect to benefits for services furnished after December 31, 2007.

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[2] The group health plan requirements do not apply to any group health plan for any plan year if, on the first day of such plan year, such plan has less than two participants who are current employees.

Description of Proposal

In general

The provision modifies the mental health parity requirements under the Code and also expands the application of such requirements to substance-related disorder benefits.[3] This expansion applies to the rules under present law and to the changes under the provision.

The provision also eliminates the sunset under present law and makes the requirements for group health plans relating to mental health and substance-related disorder benefits permanent.

Treatment limits and beneficiary financial requirements

Treatment limits

Under the provision, in the case of a group health plan that provides both medical and surgical and mental health or substance-related disorder benefits, if the plan does not include a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan may not impose any treatment limit on mental health and substance-related disorder benefits that are classified in the same category of items or services. A treatment limit means, with respect to a plan, limitation on the frequency of treatment, number of visits or days of coverage, or other similar limit on the duration or scope of treatment under the plan.

If the plan includes a treatment limit on substantially all medical and surgical benefits in any category of items or services, the plan may not impose such a treatment limit on mental health or substance-related disorder benefits for items and services within such category that is more restrictive than the predominant[4] treatment limit that is applicable to medical and surgical benefits for items and services within such category.

The provision provides five categories of items and services for benefits. All medical and surgical benefits and all mental health and substance related benefits must be classified into one of the five categories. The five categories are as follows:

1. Inpatient, in-network -- Items and services, not described in (5) below, furnished on an inpatient basis and within a network of providers established or recognized under such plan.

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[3] The term "substance related disorder benefits" means benefits with respect to services for substance-related disorders, as defined under the terms of the plan.

[4] A treatment limit 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 with respect to such category of items and services.

2. Inpatient, out-of-network -- Items and services, not described in (5) below, furnished on an inpatient basis and outside any network of providers established or recognized under such plan.

3. Outpatient, in-network -- Items and services, not described in (5) below, furnished on an outpatient basis and within a network of providers established or recognized under such plan.

4. Outpatient, out-of-network -- Items and services, not described in (5) below, furnished on an outpatient basis and outside any network of providers established or recognized under such plan.

5. Emergency care -- Items and services, whether furnished on an inpatient or outpatient basis or within or outside any network of providers, required for the treatment of an emergency medical condition (including an emergency medical condition relating to mental health or substance-related disorders).

Beneficiary financial requirements

The provision provides that in the case of a group health plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if the plan does not include a beneficiary financial requirement on substantially all medical and surgical benefits within a category of items and services (listed above), the plan may not impose such a beneficiary financial requirement on mental health or substance-related disorder benefits for items and services within such category.

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

If a plan includes a deductible, a limitation on out-of-pocket expenses, or similar beneficiary financial requirement that does not apply separately to individual items and services on substantially all medical and surgical benefits within a category of items and services, the plan must apply such requirement[5] both to medical and surgical benefits within such category and mental health and substance-related disorder benefits within such category and may not distinguish in the application of such requirement between such medical and surgical benefits and such mental health and substance-related disorder benefits.

If a plan includes a beneficiary financial requirement not described in the preceding paragraph on substantially all medical and surgical benefits within a category of items and

[5] If there is more than one such requirement for such category of items and services, the rule applies to the predominate requirement for such category. A 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 requirement with respect to such category of items and services.

services, the plan may not impose such financial requirement on mental health or substance-related disorder benefits for items and services within such category in a way that results in greater out-of-pocket expenses to the participant or beneficiary than the predominate beneficiary financial requirement applicable to medical and surgical benefits for items and services within such category. The provision does not prohibit the plan from waiving the application of any deductible for mental health benefits or substance-related disorder benefits (or both).

The provision deletes the present law rule that the mental health parity requirements should not be construed as affecting the terms and conditions of mental health benefits under a plan.

Availability of plan information regarding criteria for medical necessity

The provision also provides that the criteria for medical necessity determinations made under the plan with respect to mental health and substance-related disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contract provider upon request. The reason for any denial under the plan of reimbursement or payment for services with respect to mental health and substance-related disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator to the participant or beneficiary upon request.

Minimum benefit requirements

The provision provides rules for the minimum benefits that must be provided in the case of a plan that provides mental health and substance-related disorder benefits. Under the provision, in the case of a group health plan that provides any mental health or substance-related disorder benefits, the plan must include benefits for any mental health condition or substance-related disorder for which benefits are provided under the benefit plan option offered under the Federal Employees' Health Benefits Program (FEHBP) with the highest average enrollment as of the beginning of the most recent year beginning on or before the beginning of the plan year involved.

In the case of a plan that provides both medical and surgical benefits and mental health or substance-related disorder benefits, if medical and surgical benefits are provided for substantially all items and services in a category specified below furnished outside any network of providers established or recognized under such plan, the mental health and substance-related disorder benefits must also be provided for items and services in such category furnished outside any network of providers established or recognized under such plan in accordance with the requirements under the provision. The three categories are as follows:

1. 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).

2. Inpatient -- Items and services not described in (1) furnished on an inpatient basis.

3. Outpatient -- Items and services not described in (1) furnished on an outpatient basis.

Increased cost exception

The provision modifies the increased cost exemption under present law. Under the provision, if the application of the mental health and substance-related disorder parity requirements results in an increase for the plan year involved of the actual total costs of coverage[6] by an amount that exceeds one percent (two percent in the case of the first plan year to which the provision applies) of the actual total plan costs, such requirements do not apply to the plan during the following plan year. This exception applies to the plan for one plan year. If a plan seeks use of the exemption, the determination whether the exemption applies must be made after the plan has complied with the rules for the first six months of the plan year involved.

Determinations as to increases in actual costs under a plan for purposes of this exemption must be made by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. The determination must be certified by the actuary and made available to the general public.

The provision does not effect the application of State law requirements or exceptions.

Small employer exception

The provision also modifies the small employer exemption. Under the provision, a small employer is an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year. Under the provision, a small employer also includes an employer who employed on average at least one employee during such period in the case of an employer residing in a State that permits small groups to include a single individual.

Effective date

The provision is effective with respect to plan years beginning on or after January 1, 2008.

The elimination of the sunset of the present law mental health parity requirements is effective for benefits for services furnished after December 31, 2007.

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 enactment, the provision (other than the elimination of the sunset) does not apply to plan years beginning before the later of (1) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment), or (2) January 1, 2010. Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan

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[6] Coverage refers to medical and surgical benefits and mental health and substance-related disorder benefits under the plan.

solely to conform to any requirement imposed under the provision is not treated as a termination of such collective bargaining agreement.