

Subtitle B—Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

SEC. 511. SHORT TITLE.

This subtitle may be cited as the “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008”.

SEC. 512. MENTAL HEALTH PARITY.

(a) AMENDMENTS TO ERISA.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended—

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

“(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

“(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“(B) DEFINITIONS.—In this paragraph:

“(i) FINANCIAL REQUIREMENT.—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

“(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) TREATMENT LIMITATION.—The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

“(4) AVAILABILITY OF PLAN INFORMATION.—The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available

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

“(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).”;

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) 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 that such appears; and

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

(B) by striking paragraph (2) and inserting the following:

“(2) 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 use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

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

“(i) 2 percent in the case of the first plan year in which this section is applied; 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 section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

“(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group health 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.—

“(i) IN GENERAL.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

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

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

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

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

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

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

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

“(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.”;

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

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

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

(5) by striking subsection (f);

(6) by inserting after subsection (e) the following:

“(f) SECRETARY REPORT.—The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

“(g) NOTICE AND ASSISTANCE.—The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.”;

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

(8) by striking “mental health benefits” and inserting “mental health or substance use disorder benefits” each place it appears (other than in any provision amended by the previous paragraph).

(b) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—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:

“(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

“(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“(B) DEFINITIONS.—In this paragraph:

“(i) FINANCIAL REQUIREMENT.—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

“(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) TREATMENT LIMITATION.—The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

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

“(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).”;

(3) in subsection (c)—

(A) in paragraph (1), by inserting before the period the following: “(as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual)”;

(B) by striking paragraph (2) and inserting the following:

“(2) 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 use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

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

“(i) 2 percent in the case of the first plan year in which this section is applied; 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 section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared

by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

“(D) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connection with a group health 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.—

“(i) IN GENERAL.—A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

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

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

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

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

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

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

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

“(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.”;

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

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

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

(5) by striking subsection (f);

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

(7) by striking “mental health benefits” and inserting “mental health or substance use disorder benefits” each place it appears (other than in any provision amended by the previous paragraph).

(c) AMENDMENTS TO INTERNAL REVENUE CODE.—Section 9812 of the Internal Revenue Code of 1986 is amended—

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

“(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

“(A) IN GENERAL.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that—

“(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“(B) DEFINITIONS.—In this paragraph:

“(i) FINANCIAL REQUIREMENT.—The term ‘financial requirement’ includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

“(ii) PREDOMINANT.—A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

“(iii) TREATMENT LIMITATION.—The term ‘treatment limitation’ includes limits on the frequency of

treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

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

“(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan provides coverage for medical or surgical benefits provided by out-of-network providers, the plan shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(2) in the case of a group health plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan relating to such benefits under the plan, except as provided in subsection (a).”;

(3) in subsection (c)—

(A) by amending paragraph (1) to read as follows:

“(1) SMALL EMPLOYER EXEMPTION.—

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

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

(B) by striking paragraph (2) and inserting the following:

“(2) COST EXEMPTION.—

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

apply to such plan during the following plan year, and such exemption shall apply to the plan for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan involved regardless of any increase in total costs.

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

“(i) 2 percent in the case of the first plan year in which this section is applied; and

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

“(C) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan for a period of 6 years following the notification made under subparagraph (E).

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

“(E) NOTIFICATION.—

“(i) IN GENERAL.—A group health plan that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

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

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

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

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

“(iii) CONFIDENTIALITY.—A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not

more than an annual basis, an anonymous itemization of such notifications, that includes—

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

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

“(F) AUDITS BY APPROPRIATE AGENCIES.—To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.”;

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

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

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

(5) by striking subsection (f);

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

(7) by striking “mental health benefits” and inserting “mental health or substance use disorder benefits” each place it appears (other than in any provision amended by the previous paragraph).

(d) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c), respectively.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5), relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

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

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

(B) January 1, 2009.

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

(f) ASSURING COORDINATION.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section (and the amendments made by this section) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(g) CONFORMING CLERICAL AMENDMENTS.—

(1) ERISA HEADING.—

(A) IN GENERAL.—The heading of section 712 of the Employee Retirement Income Security Act of 1974 is amended to read as follows:

“SEC. 712. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”.

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

“Sec. 712. Parity in mental health and substance use disorder benefits.”.

(2) PHSA HEADING.—The heading of section 2705 of the Public Health Service Act is amended to read as follows:

“SEC. 2705. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”.

(3) IRC HEADING.—

(A) IN GENERAL.—The heading of section 9812 of the Internal Revenue Code of 1986 is amended to read as follows:

“SEC. 9812. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”.

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

“Sec. 9812. Parity in mental health and substance use disorder benefits.”.

(h) GAO STUDY ON COVERAGE AND EXCLUSION OF MENTAL HEALTH AND SUBSTANCE USE DISORDER DIAGNOSES.—

H. R. 1424—129

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that analyzes the specific rates, patterns, and trends in coverage and exclusion of specific mental health and substance use disorder diagnoses by health plans and health insurance. The study shall include an analysis of—

(A) specific coverage rates for all mental health conditions and substance use disorders;

(B) which diagnoses are most commonly covered or excluded;

(C) whether implementation of this Act has affected trends in coverage or exclusion of such diagnoses; and

(D) the impact of covering or excluding specific diagnoses on participants' and enrollees' health, their health care coverage, and the costs of delivering health care.

(2) REPORTS.—Not later than 3 years after the date of the enactment of this Act, and 2 years after the date of submission the first report under this paragraph, the Comptroller General shall submit to Congress a report on the results of the study conducted under paragraph (1).