TO: Dean Rosen, Rebecca Jones

FROM: Jeff Lemieux, CBO

SUBJ: Preliminary Federal Cost Estimate: Limited Mental Health Parity Proposal

DATE: 6/4/96

I have attached a preliminary federal cost estimate of your proposal for a limited parity for mental health parity. Over the ten years between 1997 and 2006, CBO and the Joint Committee on Taxation (JCT) estimate that the revised proposal mental health parity would increase the deficit by about $1.9 billion.

The revised proposal is different from the proposal in the Senate-passed plan in several ways:

Substance abuse benefits would not be subject to any mandates for parity,

Parity would apply only to two types of insurance items as specified in the proposal:

1. Aggregate lifetime limits
2. Aggregate annual limits



Plans serving employers with 25 or fewer employees would be exempt,

Plans would be allowed to have separate insurance products for mental and medical health coverage, with more stringent thresholds of management for mental health care, and

Medicare and Medicaid would be exempt.

(In its previous estimate, CBO had assumed that these last two clarifications would be made as the legislation progressed. Therefore, they do not change the federal cost estimate.)

The Congressional Research Service estimates that premiums for a typical fee-for-service plan using customary management techniques to control costs would initially increase by 0.4 percent under this proposal. This estimate has not been adjusted for the impact the proposal would have on certain managed care plans or the fact that employers with 25 or fewer employees would be exempt. Both adjustments could lower the estimated cost of

## Mental Health Parity Compromise

**1. PARITY FOR AGGREGATE LIFETIME AND ANNUAL PAYMENT LIMITS.** If a health plan has a lifetime or annual limit on what it will spend for medical or surgical services, that plan must either include services for mental illness in that total, or have a separate limit for mental illnesses that is no more restrictive than the medical/surgical limit. If a health plan does not have either of these limits for medical/surgical services, it may not limit these aspects of mental health services.

**The compromise proposal:**

- does not determine what a plan must charge for mental health services;
- does not require parity for copays and deductibles;
- does not require parity for inpatient hospital days or outpatient limits;
- excludes substance abuse and chemical dependency;
- excludes MEDICARE and MEDICAID;
- includes the Federal Employee Health Benefit Program;
- allows for managed care and mental health "carve-outs;"
- does not apply to individual health coverage;
- exempts small businesses with 25 or fewer employees.

**Cost:**

Relative to the original Domenici/Wellstone amendment passed by the Senate, the cost to both private sector premiums and the federal government has been cut by 90%.

| | Initial Premium + (Industry-wide) | Employer Contribution | Loss Revenue To Gov't |
|---|---|---|---|
| Original | 4.0% | +1.6% | $16.17 billion |
| Compromise | 0.4% | +0.16% | $ 1.8 billion |

**2. A COMMISSION ON MENTAL HEALTH PARITY.** The Commission's purpose is to review and analyze data and studies on the prevalence of mental illnesses, the efficacy and cost effectiveness of treatment for mental illnesses and to develop strategies for implementation of fair and equitable health coverage for individuals with mental illnesses. The Commission should submit its final report no later than September 1, 1998. The final report should include strategies and a timetable for implementing its recommendations.

# MEMORANDUM

September 20, 1996

**TO:** John Hilley
Jack Lew
Nancy-Ann Min
Jen Klein
Jack Ebeler
Christie Schmidt
Darrel Grinstead

**FROM:** Chris Jennings

**SUBJ:** 48 Hour Rule

---

Following our conversation this morning, I have composed a draft statement/colloquy on the 48 hour rule for your review. It is my understanding that the conference report has already been filed. Therefore, our most likely course of action may be drafting a colloquy between the appropriate members to take place on the floor prior to a final vote.

Despite the initial positive reaction by Representative Jerry Lewis (R-CA), we have subsequently learned this issue may create major problems for Representative Solomon and other Republicans. It is our understanding that they explicitly made a decision not to refer to Medicaid because they want to treat Medicaid separately and they do not want to bring another committee into the discussion (e.g., Senate Finance Committee). Senator Bradley is concerned that raising this issue may put the rest of the bill at risk. However, he will defer to us, if we believe raising the issue can lead to successful resolution without undermining the recently agreed to provision.

I would like to have a brief conference call on this issue before the end of the day.

**DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT**

**Application of 48-Hour Rule to Medicaid Contracts with Certified Health Plans**

It is our understanding that it is the intention of the statutory language (approved by the VA/HUD conferees) for the 48-hour rule provisions to apply to State-certified health plans that contract out with Medicaid. In other words, just as any other health plan in the nation must comply with the 48-hour rule, so too shall any health plan that contracts out with Medicaid. It is also our understanding that the statutory language was scored consistent with this interpretation. We believe the language is somewhat vague on this point and believe, at minimum, additional report language is necessary to clarify the intent of this provision.

**Suggested Colloquy**

**Question:** It is my understanding that the intent of the statutory language for the 48-hour rule requirements to be applied to any State-certified health plan that contracts with Medicaid. Just as any other health plan in the nation must comply with the 48-hour rule, so too shall any health plan that contracts with Medicaid. Is this correct?

**Answer:** Yes it is.

**Question:** It is also my understanding that the Congressional Budget Office has scored this provision consistent with this interpretation. Is this correct?

**Answer:** Yes it is.

**Application of 48-Hour Rule to Medicaid Contracts with Certified Health Plans**

**Background**

It is our understanding that it is the intention of the statutory language (approved by VA/HUD conferees) for the 48-hour rule provisions to apply to State-certified health plans that contract out with Medicaid. In other words, just as any other health plan in the nation must comply with the 48-hour rule, so too shall any health plan that contracts out with Medicaid. It is our understanding that the statutory language was scored consistent with this interpretation. We believe the language is somewhat vague on this point and believe, at minimum, an explanatory statement is necessary to clarify the intent of this provision.

**Suggested Bill Managers' Statement**

The intent of the statutory language is for the 48-hour rule requirements to be applied to any State-certified plan that contracts with Medicaid. Just as any other health plan in the nation must comply with the 48-hour rule, so too shall any health plan that contracts with a State to cover Medicaid beneficiaries. This interpretation is consistent with CBO's scoring of the 48-hour rule provisions.

**Presidential Statements In Support of Mental Health Parity**

*"I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity..."*

Leon Panetta
July 30, 1996

*". . . I was disappointed that the mental health provision was taken out, [of the Kennedy/Kassebaum bill] and I certainly hope we can get it as soon as possible in the future. It should remain a high priority."*

President Bill Clinton
August 1, 1996

*"I wish this bill [Kennedy/Kassebaum] had contained the provision to eliminate the differential treatment of mental health coverage, or at least taken some positive steps in that direction."*

President Bill Clinton
August 21, 1996

Sept 11th

**Presidential Statements In Support of the 48 Hour Rule**

*"I urge members of Congress to move legislation forward as soon as possible that makes this protection for mothers and their children the law of the land. No insurance company should be free to make the final judgment about what is medically best for newborns and their mothers. That decision should be left up to doctors, nurses and mothers themselves."*

President Bill Clinton
May 11, 1996

*"We should protect mothers and newborn babies from being forced out of the hospital in less than 48 hours."*

President Bill Clinton
Democratic National Convention
August 30, 1996

*". . . the President is right to support a bill that would prohibit the practice of forcing mothers and babies to leave the hospital in less than 48 hours."*

Hillary Rodham Clinton
Democratic National Convention
August 28, 1996

*"That's why I'm supporting the legislation I mentioned, dealing with not forcing new mothers and their newborns out of the hospital."*

President Bill Clinton
September 5, 1996

Sept 11th

Newt Gingrich
Sixth District
Georgia

(202) 225-0600

Office of the Speaker
United States House of Representatives
Washington, DC 20515

**FAX COVER LETTER**

**ATTENTION:** Chuck Kiefer

**FROM:** **Policy Office Staff**

| | |
|---|---|
| ____ Karen Feaga | ____ Fred Nutt |
| ____ Jack Howard | ____ Chris Scheve |
| ✓ Ed Kutler | ____ Sue Yang |
| ____ Gardner Peckham | |

**DATE:** _____

**FAX NUMBER:** _____

**TOTAL NUMBER OF PAGES (INCLUDING COVER):** 15

**COMMENTS:**

Mental health language as agreed to by Domenici and Wellstone

Agreed to by Kennedy/Wellstone

Substitute for Senate Amendment #118 to H.R. 3666 (viz., title VII):

# TITLE VII—PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS

**SEC. 701. SHORT TITLE.**

This title may be cited as the "Mental Health Parity Act of 1996".

**SEC. 702. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a)) is amended by adding at the end the following new section:

**"SEC. 712. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.**

"(a) IN GENERAL.—

"(1) AGGREGATE LIFETIME LIMITS.—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 benefits—

"(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime

limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either—

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and

surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

"(2) ANNUAL LIMITS.—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 benefits—

"(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either—

"(i) apply the applicable annual limit both to medical and surgical benefits to

which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of such a plan or coverage that provides such mental health benefits, as affecting 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 or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) EXEMPTIONS.—

"(1) SMALL EMPLOYER EXEMPTION.—

"(A) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar

year and who employs at least 2 employees on the first day of the plan year.

"(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section under such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, subsections (a) and (c) shall be applied separately with respect to each such option.

"(e) DEFINITIONS.—For purposes of this section:

"(1) AGGREGATE LIFETIME LIMIT.—The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) ANNUAL LIMIT.—The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation

on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

"(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) SUNSET.—This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, as amended by section 602 of this Act, is amended by inserting after the item relating to section 711 the following new item:

"Sec. 712. Parity in the application of certain limits to mental health benefits.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 703. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.**

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a)) is amended by adding at the end the following new section:

**"SEC. 2705. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.**

"(a) IN GENERAL.—

"(1) AGGREGATE LIFETIME LIMITS.—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 benefits—

"(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on

substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either—

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the

weighted average of the aggregate lifetime limits applicable to such categories.

"(2) ANNUAL LIMITS.—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 benefits—

"(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either—

"(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of such a plan or coverage that provides such mental health benefits, as affecting 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 or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) EXEMPTIONS.—

"(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section under such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, subsections (a) and (c) shall be applied separately with respect to each such option.

"(e) DEFINITIONS.—For purposes of this section:

"(1) AGGREGATE LIFETIME LIMIT.—The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) ANNUAL LIMIT.—The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

"(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) SUNSET.—This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

U.S. House of Representatives
Committee on Commerce

Washington, DC 20515–6115

## DEMOCRATIC STAFF

# FAX COVER SHEET

**DATE:** 9-19-96

**TO:** Chris Jennings

**FROM:** Bridgett Taylor

**FAX NUMBER:** 456-7431

**NUMBER OF PAGES:**
**(Including Cover)** 27

**COMMENTS:**

Moms language/statement VA/HUD

(If there are problems with this transmission,
please phone 202-226-3400, Democratic Staff, 564 FHOB.)

Statement of Conferees on Senate Amendment #117 to H.R. 3666 ("Newborns' and Mothers' Health Protection Act of 1996")

The conference agreement includes the Senate amendment with modifications. It incorporates the requirements of the provision and the authority to enforce the requirements into the new part 7 of subtitle B of ERISA and the new title XXVII of the Public Health Service Act as established by P.L. 104–191. It does not include the exception to the requirement for the 48-hour or 96-hour minimum stay in the case that the plan provides for post-delivery follow-up care. It adds a prohibition that a health plan cannot restrict benefits for any portion of the required minimum 48-hour or 96-hour stay in a manner which is less favorable than the benefits providing for any preceding portion of such stay. In addition, the conference agreement provides that nothing in this provision is intended to be construed as preventing a group health plan or issuer from imposing coinsurance, deductibles, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital

length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay. It is the intent of the conferees that cost-sharing not be used in a manner that circumvents the objectives of this title. It provides for a modification to the notice requirements by conforming them to the summary of material modifications under ERISA. In general, it conforms the provision relating to preemption to State laws to the Health Insurance Portability and Accountability Act of 1996. Notwithstanding section 731(a)(1) of ERISA and sections 2723(a)(1) and 2762 of the Public Health Service Act, the new provisions shall not preempt a State law that requires health insurance coverage to include coverage for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations. In addition, those sections shall not be construed as superseding a State law that leaves decisions regarding the appropriate hospital length of stay in connection with childbirth entirely to the attending provider in consultation with the mother. In addition, it is the intent of the conferees that, consistent with section 704 (redesignated as section 731) of ERISA and section 2723 of the Public Health Service

Act, the application of the preemption provision should permit the operation of any State law or provision which requires more favorable treatment of maternity coverage under health insurance coverage than that required under this title.

It is the intent of the conferees that health plans have sufficient flexibility to encourage or specify that attending providers follow nationally recognized guidelines for maternal and perinatal care in determining when early discharge is medically appropriate.

Throughout the title, the conferees have used the term "hospital length of stay" to indicate that the requirement for coverage of a 48-hour stay following vaginal delivery and a 96-hour length of stay following a cesarean section delivery is triggered by any delivery in connection with hospital care, regardless of whether the delivery is in a hospital inpatient or outpatient setting.

It is the intent of the conferees that a detailed series of conforming changes shall be made as soon as possible to the Internal Revenue Code, specifically subtitle K of the Internal Revenue Code of 1986 (as added by section 401(a) of the Health Insurance Portability and Accountability Act of 1996), in order to fully implement these provisions as part of chapter 100 of the Code.

Substitute for Senate Amendment #117 to H.R. 3666 (viz., title VI):

# TITLE VI—NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

SEC. 601. SHORT TITLE.

This title may be cited as the "Newborns' and Mothers' Health Protection Act of 1996".

SEC. 602. FINDING.

Congress finds that—

(1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and

(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.

SEC. 603. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (added by section 101(a) of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by amending the heading of the part to read as follows:

"PART 7—GROUP HEALTH PLAN REQUIREMENTS";

(2) by inserting after the part heading the following:

"SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY";

(3) by redesignating sections 704 through 707 as sections 731 through 734, respectively;

(4) by inserting before section 731 (as so redesignated) the following new heading:

"SUBPART C—GENERAL PROVISIONS";

and

(5) by inserting after section 703 the following new subpart:

"SUBPART B—OTHER REQUIREMENTS

"SEC. 711. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

"(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

"(A) except as provided in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

"(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is

made by an attending provider in consultation with the mother.

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

"(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

"(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care in accordance with this section;

"(4) provide incentives (monetary or otherwise) to a provider to induce such provider to provide care to a participant or beneficiary in a manner inconsistent with this section; or

"(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a

manner which is less favorable than the benefits provided for any preceding portion of such stay.

"(c) RULES OF CONSTRUCTION.—

"(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

"(A) to give birth in a hospital; or

"(B) to stay in the hospital for a fixed period of time following the birth of her child.

"(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

"(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not

be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

"(d) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

"(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

"(f) PREEMPTION.—

"(1) IN GENERAL.—Notwithstanding section 731(a)(1), the provisions of this section shall not preempt a State law (as defined in section 731(d)(1)) that requires health insurance coverage to include coverage for maternity and pediatric care in accordance with guidelines established by the

American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed as superseding a State law (as so defined) that leaves decisions regarding the appropriate hospital length of stay in connection with childbirth entirely to the attending provider in consultation with the mother.".

(b) CONFORMING AMENDMENTS.—

(1) Section 731(c) of such Act (as added by section 101 of the Health Insurance Portability and Accountability Act of 1996 and redesignated by the preceding provisions of this section) is amended by striking "Nothing" and inserting "Except as provided in section 711, nothing".

(2) Section 732(a) of such Act (as added by section 101 of the Health Insurance Portability and Accountability Act of 1996 and redesignated by the preceding provisions of this section) is amended by inserting "(other than section 711)" after "part".

(3) Title I of such Act (as amended by section 101 of the Health Insurance Portability and Accountability Act of 1996 and the preceding provisions of this section) is further amended—

(A) in the last sentence of section 4(b), by striking "section 706(b)(2)", "section 706(b)(1)", and "section 706(a)(1)" and inserting "section 733(b)(2)", "section 733(b)(1)", and "section 733(a)(1)", respectively;

(B) in section 101(g), by striking "section 706(a)(2)" and inserting "section 733(a)(2)";

(C) in section 102(b), by striking "section 706(a)(1)" each place it appears and inserting "section 733(a)(1), and by striking "section 706(b)(2)" and inserting "section 733(b)(2)";

(D) in section 104(b)(1), by striking "section 706(a)(1)" each place it appears and inserting "section 733(a)(1);

(E) in section 502(b)(3), by striking "section 706(a)(1)" and inserting "section 733(a)(1)";

(F) in section 506(c), by striking "section 706(a)(2)" and inserting "section 733(a)(2)";

(G) in section 514(b)(9), by striking "section 704" and inserting "section 731";

(H) in the last sentence of section 701(c)(1), by striking "section 706(c)" and inserting "section 733(c)";

(I) in section 732(b), by striking "section 706(c)(1)" and inserting "section 733(c)(1)";

(J) in section 732(c)(1), by striking "section 706(c)(2)" and inserting "section 733(c)(2)";

(K) in section 732(c)(2), by striking "section 706(c)(3)" and inserting "section 733(c)(3)"; and

(L) in section 732(c)(3), by striking "section 706(c)(4)" and inserting "section 733(c)(4)".

(4) The table of contents in section 1 of such Act is amended by striking the items relating to part 7 and inserting the following:

"PART 7—GROUP HEALTH PLAN REQUIREMENTS

"SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY

"Sec. 701. Increased portability through limitation on preexisting condition exclusions.
"Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.
"Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

"SUBPART B—OTHER REQUIREMENTS

"Sec. 711. Standards relating to benefits for mothers and newborns.

"SUBPART C—GENERAL PROVISIONS

"Sec. 731. Preemption; State flexibility; construction.
"Sec. 732. Special rules relating to group health plans.
"Sec. 733. Definitions.
"Sec. 734. Regulations.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 604. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.**

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by amending the title heading to read as follows:

"TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE";

(2) by redesignating subparts 2 and 3 of part A as subparts 3 and 4 of such part;

(3) by inserting after subpart 1 of part A the following new subpart:

"Subpart 2—Other Requirements

**"SEC. 2704. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.**

"(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

"(A) except as provided in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

"(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours, or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

"(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

"(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of a provider because such provider provided care in accordance with this section;

"(4) provide incentives (monetary or otherwise) to a provider to induce such provider to provide care to a participant or beneficiary in a manner inconsistent with this section; or

"(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

"(c) RULES OF CONSTRUCTION.—

"(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

"(A) to give birth in a hospital; or

"(B) to stay in the hospital for a fixed period of time following the birth of her child.

"(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

"(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

"(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

"(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

"(f) PREEMPTION.—

"(1) IN GENERAL.—Notwithstanding section 2723(a)(1), the provisions of this section shall not preempt a State law (as defined in section 2723(d)(1)) that requires health insurance coverage to include coverage for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed as superseding a State law (as so defined) that leaves decisions regarding the appropriate hospital length of stay in connection with

childbirth entirely to the attending provider in consultation with the mother.".

(b) CONFORMING AMENDMENTS.—

(1) Section 2721 of such Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(A) in subsection (a), by striking "subparts 1 and 2" and inserting "subparts 1 and 3", and

(B) in subsections (b) through (d), by striking "subparts 1 and 2" each place it appears and inserting "subparts 1 through 3".

(2) Section 2723(c) of such Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended by inserting "(other than section 2704)" after "part".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 605. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.**

(a) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (as added by section 111 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by inserting after the part heading the following:

"Subpart 1—Portability, Access, and Renewability Requirements";

(2) by redesignating sections 2745, 2746, and 2747 as sections 2761, 2762, and 2763, respectively;

(3) by inserting before section 2761 (as so redesignated) the following:

"Subpart 3—General Provisions"; and

(4) by inserting after section 2744 the following:

"Subpart 3—Other Requirements

**"SEC. 2751. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.**

"(a) IN GENERAL.—The provisions of section 2704 (other than subsections (d) and (f)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

"(b) NOTICE REQUIREMENT.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the require-

ments referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.

"(c) PREEMPTION.—

"(1) IN GENERAL.—Notwithstanding section 2762(a)), the provisions of this section shall not preempt a State law (as defined in section 2723(d)(1)) that requires health insurance coverage to include coverage for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(2) CONSTRUCTION.—Section 2762(a) shall not be construed as superseding a State law (as so defined) that leaves decisions regarding the appropriate hospital length of stay in connection with childbirth entirely to the attending provider in consultation with the mother.".

(b) CONFORMING AMENDMENTS.—Such part (as so added) is further amended as follows:

(1) In section 2744(a)(1), strike "2746(b)" and insert "2762(b)".

(2) In section 2745(a)(1) (before redesignation under subsection (a)(1)), strike "2746" and insert "2762".

(3) In section 2746(b) (before redesignation under subsection (a)(1))—

(A) by inserting "(1)" after the dash, and

(B) by adding at the end the following:

"(2) Nothing in this part (other than section 2751) shall be construed as requiring health insurance coverage offered in the individual market to provide specific benefits under the terms of such coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998.

SEC. 606. REPORTS TO CONGRESS CONCERNING CHILDBIRTH.

(a) FINDINGS.—Congress finds that—

(1) childbirth is one part of a continuum of experience that includes prepregnancy, pregnancy and prenatal care, labor and delivery, the immediate postpartum period, and a longer period of adjustment for the newborn, the mother, and the family;

(2) health care practices across this continuum are changing in response to health care financing

and delivery system changes, science and clinical research, and patient preferences; and

(3) there is a need—

(A) to examine the issues and consequences associated with the length of hospital stays following childbirth;

(B) to examine the follow-up practices for mothers and newborns used in conjunction with shorter hospital stays;

(C) to identify appropriate health care practices and procedures with regard to the hospital discharge of newborns and mothers;

(D) to examine the extent to which such care is affected by family and environmental factors; and

(E) to examine the content of care during hospital stays following childbirth.

(b) ADVISORY PANEL.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish an advisory panel (referred to in this section as the "advisory panel")—

(A) to guide and review methods, procedures, and data collection necessary to conduct the study described in subsection (c) in a manner that is intended to enhance the quality, safety, and effectiveness of health care services provided to mothers and newborns;

(B) to develop a consensus among the members of the advisory panel regarding the appropriateness of the specific requirements of this title; and

(C) to prepare and submit to the Secretary, as part of the report of the Secretary submitted under subsection (d), a report summarizing the consensus (if any) developed under subparagraph (B) or the reasons for not reaching such a consensus.

(2) PARTICIPATION.—

(A) DEPARTMENT REPRESENTATIVES.—The Secretary shall ensure that representatives from within the Department of Health and Human Services that have expertise in the area of maternal and child health or in outcomes research are appointed to the advisory panel.

(B) REPRESENTATIVES OF PUBLIC AND PRIVATE SECTOR ENTITIES.—

(i) IN GENERAL.—The Secretary shall ensure that members of the advisory panel include representatives of public and private sector entities having knowledge or experience in one or more of the following areas:

(I) Patient care.

(II) Patient education.

(III) Quality assurance.

(IV) Outcomes research.

(V) Consumer issues.

(ii) REQUIREMENT.—The panel shall include representatives of each of the following categories:

(I) Health care practitioners.

(II) Health plans.

(III) Hospitals.

(IV) Employers.

(V) States.

(VI) Consumers.

(c) STUDIES.—

(1) IN GENERAL.—The Secretary shall conduct a study of—

(A) the factors affecting the continuum of care with respect to maternal and child health care, including outcomes following childbirth;

(B) the factors determining the length of hospital stay following childbirth;

(C) the diversity of negative or positive outcomes affecting mothers, infants, and families;

(D) the manner in which post natal care has changed over time and the manner in which that care has adapted or related to changes in the length of hospital stay, taking into account—

(i) the types of post natal care available and the extent to which such care is accessed; and

(ii) the challenges associated with providing post natal care to all populations, including vulnerable populations, and solutions for overcoming these challenges; and

(E) the financial incentives that may—

(i) impact the health of newborns and mothers; and

(ii) influence the clinical decisionmaking of health care providers.

(2) RESOURCES.—The Secretary shall provide to the advisory panel the resources necessary to carry out the duties of the advisory panel.

(d) REPORTS.—

(1) IN GENERAL.—The Secretary shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains—

(A) a summary of the study conducted under subsection (c);

(B) a summary of the best practices used in the public and private sectors for the care of newborns and mothers;

(C) recommendations for improvements in prenatal care, post natal care, delivery and follow-up care, and whether the implementation of such improvements should be accomplished by the private health care sector, Federal or State governments, or any combination thereof; and

(D) limitations on the databases in existence on the date of the enactment of this Act.

(2) DEADLINES.—The Secretary shall prepare and submit to the Committees referred to in paragraph (1)—

(A) an initial report concerning the study conducted under subsection (c) and elements described in paragraph (1), not later than 18 months after the date of the enactment of this Act;

(B) an interim report concerning such study and elements not later than 3 years after the date of the enactment of this Act; and

(C) a final report concerning such study and elements not later than 5 years after the date of the enactment of this Act.

(e) TERMINATION OF PANEL.—The advisory panel shall terminate on the date that occurs 60 days after the date on which the last report is submitted under subsection (d).

# MEMORANDUM

September 11, 1996

**TO:** Carol Rasco
Laura Tyson

**FROM:** Chris Jennings/Jen Klein

**SUBJ:** President sends letter to Gingrich on health provisions . . . Congress responds

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As you know, early this morning the President sent a letter to Representative Gingrich urging the House to "act quickly to enact three important health reform provisions." (See attached)

Later today, the House passed a motion (392 to 17) offered by Representative Stokes (D-OH) to instruct VA-HUD conferees to (1) assure new mothers and their babies the option of a 48-hour post-delivery hospital stay, (2) move toward providing mental health coverage parity, and (3) provide protections for the children of Vietnam veterans who are born with the birth defect spina bifida. This motion contains all of the provisions referenced in the President's letter. (Please see attached AP story).

This vote is likely to assure that the 48-hour rule and the spina bifida provisions will be sent up in the final VA-HUD Appropriations bill. Notwithstanding this vote, the mental health parity provision is still a long shot. We will keep you informed of developments.

THE WHITE HOUSE

WASHINGTON

September 11, 1996

The Honorable Newt Gingrich
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

I am writing to urge the House to act quickly to enact three important health reform provisions that were passed by the Senate last week. I encourage you to work toward the speedy passage of provisions that (1) assure new mothers and their babies the option of a 48-hour post-delivery hospital stay, (2) move toward providing mental health coverage parity, and (3) provide protections for the children of Vietnam veterans who are born with the birth defect spina bifida.

First, we should enact bipartisan legislation to require health insurers to let all new mothers and their babies stay in the hospital at least 48 hours following normal deliveries. Over the past two decades, the average length of stay for an uncomplicated childbirth has fallen sharply. A large and growing number of health plans are refusing to pay for anything more than a 24-hour stay, except in the most extreme circumstances, and some have recommended releasing new mothers as early as eight hours after delivery. Enactment of this measure would give peace of mind to families who will no longer have to fear that new mothers will be prematurely discharged from the hospital.

Second, we should ensure that the Domenici/Wellstone mental health parity compromise becomes law. This legislation would prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long; it is time that we take steps to end this inequity.

Finally, we should act now to give the Veterans' Administration authority to help the children of Vietnam veterans who are born with the birth defect spina bifida. Studies have shown a positive link between this condition and parental exposure to Agent Orange during service in Vietnam. This legislation would provide health care, vocational training, and a monthly monetary allowance to these children, fulfilling our commitment to them.

I urge you to do all you can to ensure passage of these important initiatives, either as part of the VA-HUD appropriations bill, or in any other vehicle in which passage by both Houses can be assured before Congress adjourns. In so doing, we will improve the quality of health care for some of our most vulnerable populations.

Sincerely,

Date: 09/11/96 Time: 17:20
CClinton Urges Passage of Health-Related Legislation

WASHINGTON (AP) President Clinton urged the Republican-controlled House on Wednesday to pass three health-related pieces of legislation, including one that would assure a two-day hospital stay for new mothers.

The House quickly concurred, voting 392-17 to endorse the three measures approved by the Senate last week as amendments to a 1997 spending bill.

In addition to assuring that insurance companies pay for at least 48 hours in the hospital for mothers after delivery, the measures would close the gap between insurance coverage for mental and physical illnesses and give benefits to veterans exposed to Agent Orange during the Vietnam War whose offspring suffer from spina bifida, a crippling birth defect.

The House vote instructed House members of a House-Senate conference to accept the Senate-approved measures as they work out differences on an $84 billion bill to fund veterans, housing, space and other programs in fiscal 1997. The action is not binding, but the size of the vote makes it almost certain the House conferees will accept the Senate amendments.

In a letter to House Speaker Newt Gingrich, Clinton also pressed for approval of the mental illness and Agent Orange bills.

The letter, which was released Wednesday at the White House while the president campaigned in Colorado, said that by passing the bills, ''we will improve the quality of health care for some of our most vulnerable populations.''

Referring to the time new mothers are allowed to remain in the hospital after giving birth, Clinton said a large and growing number of health plans now refuse to pay for anything more than a 24-hour stay except in extreme circumstances.

''Some have recommended releasing new mothers as early as eight hours after delivery,'' he said. ''Enactment of this measure would give peace of mind to families who will no longer have to fear that new mothers will be prematurely discharged from the hospital.''

Clinton also endorsed legislation sponsored by Sens. Pete Domenici, R-N.M., and Paul Wellstone, D-Minn., that would prohibit health insurers from setting separate lifetime and annual limits for mental health benefits.

''People with mental illness have faced discrimination in health insurance coverage for far too long. It is time that we take steps to end this inequity,'' the president said.

On the veterans measure, he wrote that ''studies have shown a positive link between this condition (spina bifida) and parental exposure to Agent Orange during service in Vietnam.''

''This legislation would provide health care, vocational training, and a monthly monetary allowance to these children, fulfilling our commitment to them,'' Clinton said.

The letter did not specify how much any these programs would cost.

Republican leaders urged their members against hasty acceptance of what they said were measures aimed at pleasing interest groups just before the election, but all but 16 Republicans and one

Democrat voted to endorse the three measures.

Appropriations Committee Chairman Rep. Bob Livingston, R-La., said lawmakers ''risk a great danger that we in the haste of trying to do good things in advance of an election all of a sudden adopt measures in such a legislative domain that later on prove to be ill-advised.''

Keeping the three measures in the Veterans Affairs-Housing and Urban Development spending bill would also put greater pressure on Clinton to sign legislation he has indicated that he might veto.

The administration has objected to cuts in housing programs and the House decision to eliminate all funding for AmeriCorps, the president's national service program. The Senate allocated $400 million for AmeriCorps, still more than $100 million under the administration request.

APNP-09-11-96 1730EDT

## Statement by the President

I am pleased that the conferees on the VA-HUD appropriations bill have responded to my challenge to pass two provisions that will give vital health care services and peace of mind to American families.

As I wrote in my September 11 letter to Speaker Gingrich urging the House to pass these measures, the first provision requires health insurers to let all new mothers and their babies stay in the hospital at least 48 hours following normal deliveries. Over the past few decades, the average length of stay for an uncomplicated childbirth has fallen sharply. A large and growing number of health plans refuse to pay for anything more than a 24 hour stay, except in the most extreme circumstances, and some release mothers as early as eight hours after delivery. This can pose serious health risks for both mothers and newborns. We owe all new mothers the assurance that when they bring a baby into this world, they will not be rushed out of the hospital until they and their health care provider decide it is medically safe for both mother and child.

The second provisions prohibits health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long; it is time that we take steps to end this inequity.

I hope that the conferees will now pass the provision protecting the children of Vietnam veterans who are born with spina bifida. I also look forward to prompt action by the House and Senate on all of these measures.

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

On April 23, 1996, by an overwhelmingly bipartisan vote of 68-30, the Senate passed a Domenici/Wellstone amendment which would have required health plans to treat mental health coverage on an equal footing with other health benefits. The Domenici/Wellstone amendment would have ended the most egregious inequities in coverage for mental illness.

Despite this impressive vote, concerns about the potential cost of this amendment were raised. In response, Senator Domenici dropped all of the mental health parity requirements in the amendment except equitable treatment of lifetime and annual limits. According to the Congressional Budget Office (CBO), Senator Domenici's compromise would cost 90 percent less than the original amendment ($966 million). CBO has also estimated that the proposal would increase insurance premiums by 0.4 percent at most.

The President feels strongly that Senator Domenici's compromise should be the acceptable bipartisan alternative to the Senate passed amendment. I urge you and all conferees to incorporate his proposal into the bill reported out by the conference. We look forward to reaching prompt agreement on this and all the other important provisions of H.R. 3103.

Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Bill Archer
Chairman
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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The President feels strongly that Senator Domenici's compromise should be the acceptable bipartisan alternative to the Senate passed amendment. I urge you and all conferees to incorporate his proposal into the bill reported out by the conference. We look forward to reaching prompt agreement on this and all the other important provisions of H.R. 3103.

Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable William M. Thomas
Chairman
Committee on House Oversight
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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The President feels strongly that Senator Domenici's compromise should be the acceptable bipartisan alternative to the Senate passed amendment. I urge you and all conferees to incorporate his proposal into the bill reported out by the conference. We look forward to reaching prompt agreement on this and all the other important provisions of H.R. 3103.

Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Thomas J. Bliley, Jr.
Chairman
Committee on Commerce
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Bilirakis:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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The President feels strongly that Senator Domenici's compromise should be the acceptable bipartisan alternative to the Senate passed amendment. I urge you and all conferees to incorporate his proposal into the bill reported out by the conference. We look forward to reaching prompt agreement on this and all the other important provisions of H.R. 3103.

Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Michael Bilirakis
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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The President feels strongly that Senator Domenici's compromise should be the acceptable bipartisan alternative to the Senate passed amendment. I urge you and all conferees to incorporate his proposal into the bill reported out by the conference. We look forward to reaching prompt agreement on this and all the other important provisions of H.R. 3103.

Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable William F. Goodling
Chairman
Committee on Economic and Educational Opportunity
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Fawell:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Harris W. Fawell
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Henry J. Hyde
Chairman
Committee on Judiciary
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative McCollum:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Bill McCollum
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Hastert:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Dennis Hastert
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Gibbons:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Sam M. Gibbons
Ranking Member
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Stark:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Pete Stark
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Dingell:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable John D. Dingell
Ranking Member
Committee on Commerce
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Waxman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Henry A. Waxman
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Clay:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable William (Bill) Clay
Ranking Member
Committee on Economic and Educational Opportunities
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Conyers:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable John Conyers, Jr.
Ranking Member
Committee on Judiciary
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Representative Bonior:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable David E. Bonior
Democratic Whip
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Leader:

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Sincerely,

John D. Panetta
Chief of Staff

The Honorable Trent Lott
Majority Leader
United States Senate
Washington, D.C. 20510

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Senator Kennedy:

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Leon E. Panetta
Chief of Staff

The Honorable Edward M. Kennedy
Ranking Member
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Senator Moynihan:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Daniel Patrick Moynihan
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Mr. Chairman:

I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity by including the Domenici alternative in the final version of the Health Insurance Portability and Accountability Act (H.R. 3103) presented by the conference to the Congress.

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

THE WHITE HOUSE

WASHINGTON

July 30, 1996

Dear Madam Chair:

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Sincerely,

Leon E. Panetta
Chief of Staff

The Honorable Nancy Landon Kassebaum
Chairman
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

AMENDMENT NUMBERED 117

That the House recede from its disagreement to the amendment of the Senate numbered 117, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert:

# TITLE VI—NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

SEC. 601. SHORT TITLE.

This title may be cited as the "Newborns' and Mothers' Health Protection Act of 1996".

SEC. 602. FINDING.

Congress finds that—

(1) the length of post-delivery hospital stay should be based on the unique characteristics of each mother and her newborn child, taking into consideration the health of the mother, the health and stability of the newborn, the ability and confidence of the mother and the father to care for their newborn, the adequacy of support systems at home, and the access of the mother and her newborn to appropriate follow-up health care; and

(2) the timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.

ETAL

SEC. 603. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (added by section 101(a) of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by amending the heading of the part to read as follows:

"PART 7—GROUP HEALTH PLAN REQUIREMENTS";

(2) by inserting after the part heading the following:

"SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY";

(3) by redesignating sections 704 through 707 as sections 731 through 734, respectively;

(4) by inserting before section 731 (as so redesignated) the following new heading:

"SUBPART C—GENERAL PROVISIONS";

and

(5) by inserting after section 703 the following new subpart:

"SUBPART B—OTHER REQUIREMENTS

**"SEC. 711. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.**

"(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

"(A) except as provided in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

"(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is

made by an attending provider in consultation with the mother.

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

"(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

"(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

"(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

"(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital

length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

"(c) RULES OF CONSTRUCTION.—

"(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

"(A) to give birth in a hospital; or

"(B) to stay in the hospital for a fixed period of time following the birth of her child.

"(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

"(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital

length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

"(d) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.

"(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

"(f) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

"(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 731(d)(1)) for a State that regulates such

coverage that is described in any of the following subparagraphs:

"(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

"(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

"(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed as superseding a State law described in paragraph (1).".

(b) CONFORMING AMENDMENTS.—

(1) Section 731(c) of such Act (as added by section 101 of the Health Insurance Portability and Accountability Act of 1996 and redesignated by the preceding provisions of this section) is amended by striking "Nothing" and inserting "Except as provided in section 711, nothing".

(2) Section 732(a) of such Act (as added by section 101 of the Health Insurance Portability and Accountability Act of 1996 and redesignated by the preceding provisions of this section) is amended by inserting "(other than section 711)" after "part".

(3) Title I of such Act (as amended by section 101 of the Health Insurance Portability and Accountability Act of 1996 and the preceding provisions of this section) is further amended—

(A) in the last sentence of section 4(b), by striking "section 706(b)(2)", "section 706(b)(1)", and "section 706(a)(1)" and inserting "section 733(b)(2)", "section 733(b)(1)", and "section 733(a)(1)", respectively;

(B) in section 101(g), by striking "section 706(a)(2)" and inserting "section 733(a)(2)";

(C) in section 102(b), by striking "section 706(a)(1)" each place it appears and inserting

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"section 733(a)(1), and by striking "section 706(b)(2)" and inserting "section 733(b)(2)";

(D) in section 104(b)(1), by striking "section 706(a)(1)" each place it appears and inserting "section 733(a)(1);

(E) in section 502(b)(3), by striking "section 706(a)(1)" and inserting "section 733(a)(1)";

(F) in section 506(c), by striking "section 706(a)(2)" and inserting "section 733(a)(2)";

(G) in section 514(b)(9), by striking "section 704" and inserting "section 731";

(H) in the last sentence of section 701(c)(1), by striking "section 706(c)" and inserting "section 733(c)";

(I) in section 732(b), by striking "section 706(c)(1)" and inserting "section 733(c)(1)";

(J) in section 732(c)(1), by striking "section 706(c)(2)" and inserting "section 733(c)(2)";

(K) in section 732(c)(2), by striking "section 706(c)(3)" and inserting "section 733(c)(3)"; and

(L) in section 732(c)(3), by striking "section 706(c)(4)" and inserting "section 733(c)(4)".

(4) The table of contents in section 1 of such Act is amended by striking the items relating to part 7 and inserting the following:

"PART 7—GROUP HEALTH PLAN REQUIREMENTS

"SUBPART A—REQUIREMENTS RELATING TO PORTABILITY, ACCESS, AND RENEWABILITY

"Sec. 701. Increased portability through limitation on preexisting condition exclusions.
"Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.
"Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

"SUBPART B—OTHER REQUIREMENTS

"Sec. 711. Standards relating to benefits for mothers and newborns.

"SUBPART C—GENERAL PROVISIONS

"Sec. 731. Preemption; State flexibility; construction.
"Sec. 732. Special rules relating to group health plans.
"Sec. 733. Definitions.
"Sec. 734. Regulations.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 604. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.**

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by amending the title heading to read as follows:

"TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE";

(2) by redesignating subparts 2 and 3 of part A as subparts 3 and 4 of such part;

(3) by inserting after subpart 1 of part A the following new subpart:

"Subpart 2—Other Requirements

"SEC. 2704. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.

"(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING BIRTH.—

"(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

"(A) except as provided in paragraph (2)—

"(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

"(ii) restrict benefits for any hospital length of stay in connection with childbirth

for the mother or newborn child, following a cesarean section, to less than 96 hours, or

"(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

"(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by an attending provider in consultation with the mother.

"(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

"(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

"(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

"(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

"(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

"(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

"(c) RULES OF CONSTRUCTION.—

"(1) Nothing in this section shall be construed to require a mother who is a participant or beneficiary—

"(A) to give birth in a hospital; or

"(B) to stay in the hospital for a fixed period of time following the birth of her child.

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"(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

"(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

"(d) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

"(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a

group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

"(f) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

"(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

"(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

"(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

"(2) CONSTRUCTION.—Section 2723(a)(1) shall not be construed as superseding a State law described in paragraph (1).".

(b) CONFORMING AMENDMENTS.—

(1) Section 2721 of such Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(A) in subsection (a), by striking "subparts 1 and 2" and inserting "subparts 1 and 3", and

(B) in subsections (b) through (d), by striking "subparts 1 and 2" each place it appears and inserting "subparts 1 through 3".

(2) Section 2723(c) of such Act (as added by section 102 of the Health Insurance Portability and Accountability Act of 1996) is amended by inserting "(other than section 2704)" after "part".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 605. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.**

(a) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (as added by section 111 of the Health Insurance Portability and Accountability Act of 1996) is amended—

(1) by inserting after the part heading the following:

"Subpart 1—Portability, Access, and Renewability Requirements";

(2) by redesignating sections 2745, 2746, and 2747 as sections 2761, 2762, and 2763, respectively;

(3) by inserting before section 2761 (as so redesignated) the following:

"Subpart 3—General Provisions"; and

(4) by inserting after section 2744 the following:

"Subpart 3—Other Requirements

**"SEC. 2751. STANDARDS RELATING TO BENEFITS FOR MOTHERS AND NEWBORNS.**

"(a) IN GENERAL.—The provisions of section 2704 (other than subsections (d) and (f)) shall apply to health

insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

"(b) NOTICE REQUIREMENT.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.

"(c) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

"(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

"(A) Such State law requires such coverage to provide for at least a 48-hour hospital length of stay following a normal vaginal delivery and at least a 96-hour hospital length of stay following a cesarean section.

"(B) Such State law requires such coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(C) Such State law requires, in connection with such coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the mother.

"(2) CONSTRUCTION.—Section 2762(a) shall not be construed as superseding a State law described in paragraph (1).".

(b) CONFORMING AMENDMENTS.—Such part (as so added) is further amended as follows:

(1) In section 2744(a)(1), strike "2746(b)" and insert "2762(b)".

(2) In section 2745(a)(1) (before redesignation under subsection (a)(1)), strike "2746" and insert "2762".

(3) In section 2746(b) (before redesignation under subsection (a)(1))—

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(A) by inserting "(1)" after the dash, and

(B) by adding at the end the following:

"(2) Nothing in this part (other than section 2751) shall be construed as requiring health insurance coverage offered in the individual market to provide specific benefits under the terms of such coverage.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998.

**SEC. 606. REPORTS TO CONGRESS CONCERNING CHILDBIRTH.**

(a) FINDINGS.—Congress finds that—

(1) childbirth is one part of a continuum of experience that includes prepregnancy, pregnancy and prenatal care, labor and delivery, the immediate postpartum period, and a longer period of adjustment for the newborn, the mother, and the family;

(2) health care practices across this continuum are changing in response to health care financing and delivery system changes, science and clinical research, and patient preferences; and

(3) there is a need—

(A) to examine the issues and consequences associated with the length of hospital stays following childbirth;

(B) to examine the follow-up practices for mothers and newborns used in conjunction with shorter hospital stays;

(C) to identify appropriate health care practices and procedures with regard to the hospital discharge of newborns and mothers;

(D) to examine the extent to which such care is affected by family and environmental factors; and

(E) to examine the content of care during hospital stays following childbirth.

(b) ADVISORY PANEL.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish an advisory panel (referred to in this section as the "advisory panel")—

(A) to guide and review methods, procedures, and data collection necessary to conduct the study described in subsection (c) in a manner that is intended to enhance the quality,

safety, and effectiveness of health care services provided to mothers and newborns;

(B) to develop a consensus among the members of the advisory panel regarding the appropriateness of the specific requirements of this title; and

(C) to prepare and submit to the Secretary, as part of the report of the Secretary submitted under subsection (d), a report summarizing the consensus (if any) developed under subparagraph (B) or the reasons for not reaching such a consensus.

(2) PARTICIPATION.—

(A) DEPARTMENT REPRESENTATIVES.—The Secretary shall ensure that representatives from within the Department of Health and Human Services that have expertise in the area of maternal and child health or in outcomes research are appointed to the advisory panel.

(B) REPRESENTATIVES OF PUBLIC AND PRIVATE SECTOR ENTITIES.—

(i) IN GENERAL.—The Secretary shall ensure that members of the advisory panel include representatives of public and private sector entities having knowledge or

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experience in one or more of the following areas:

(I) Patient care.

(II) Patient education.

(III) Quality assurance.

(IV) Outcomes research.

(V) Consumer issues.

(ii) REQUIREMENT.—The panel shall include representatives of each of the following categories:

(I) Health care practitioners.

(II) Health plans.

(III) Hospitals.

(IV) Employers.

(V) States.

(VI) Consumers.

(c) STUDIES.—

(1) IN GENERAL.—The Secretary shall conduct a study of—

(A) the factors affecting the continuum of care with respect to maternal and child health care, including outcomes following childbirth;

(B) the factors determining the length of hospital stay following childbirth;

(C) the diversity of negative or positive outcomes affecting mothers, infants, and families;

(D) the manner in which post natal care has changed over time and the manner in which that care has adapted or related to changes in the length of hospital stay, taking into account—

(i) the types of post natal care available and the extent to which such care is accessed; and

(ii) the challenges associated with providing post natal care to all populations, including vulnerable populations, and solutions for overcoming these challenges; and

(E) the financial incentives that may—

(i) impact the health of newborns and mothers; and

(ii) influence the clinical decisionmaking of health care providers.

(2) RESOURCES.—The Secretary shall provide to the advisory panel the resources necessary to carry out the duties of the advisory panel.

(d) REPORTS.—

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(1) IN GENERAL.—The Secretary shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives a report that contains—

(A) a summary of the study conducted under subsection (c);

(B) a summary of the best practices used in the public and private sectors for the care of newborns and mothers;

(C) recommendations for improvements in prenatal care, post natal care, delivery and follow-up care, and whether the implementation of such improvements should be accomplished by the private health care sector, Federal or State governments, or any combination thereof; and

(D) limitations on the databases in existence on the date of the enactment of this Act.

(2) DEADLINES.—The Secretary shall prepare and submit to the Committees referred to in paragraph (1)—

(A) an initial report concerning the study conducted under subsection (c) and elements described in paragraph (1), not later than 18

TITLE VI - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Amendment No. 117:

The conference agreement includes the Senate amendment with modifications, including the deletion of offsets. It incorporates the requirements of the provision and the authority to enforce the requirements into the new part 7 of subtitle B of ERISA and the new title XXVII of the Public Health Service Act as established by P.L. 104–191. It does not include the exception to the requirement for the 48-hour or 96-hour minimum stay in the case that the plan provides for post-delivery follow-up care. It adds a prohibition that a health plan cannot restrict benefits for any portion of the required minimum 48-hour or 96-hour stay in a manner which is less favorable than the benefits providing for any preceding portion of such stay. In addition, the conference agreement provides that nothing in this provision is intended to be construed as preventing a group health plan or issuer from imposing coinsurance, deductibles, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital

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length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay. It is the intent of the conferees that cost-sharing not be used in a manner that circumvents the objectives of this title. It provides for a modification to the notice requirements by conforming them to the summary of material modifications under ERISA. In general, it conforms the provision relating to preemption to State laws to the Health Insurance Portability and Accountability Act of 1996. Notwithstanding section 731(a)(1) of ERISA and sections 2723(a)(1) and 2762 of the Public Health Service Act, the new provisions shall not preempt a State law that requires health insurance coverage to include coverage for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations. In addition, those sections shall not be construed as superseding a State law that leaves decisions regarding the appropriate hospital length of stay in connection with childbirth entirely to the attending provider in consultation with the mother. In addition, it is the intent of the conferees that, consistent with section 704 (redesignated as section 731) of ERISA and section 2723 of the Public Health Service

Act, the application of the preemption provision should permit the operation of any State law or provision which requires more favorable treatment of maternity coverage under health insurance coverage than that required under this title.

It is the intent of the conferees that health plans have sufficient flexibility to encourage or specify that attending providers follow nationally recognized guidelines for maternal and perinatal care in determining when early discharge is medically appropriate.

Throughout the title, the conferees have used the term "hospital length of stay" to indicate that the requirement for coverage of a 48-hour stay following vaginal delivery and a 96-hour length of stay following a cesarean section delivery is triggered by any delivery in connection with hospital care, regardless of whether the delivery is in a hospital inpatient or outpatient setting.

It is the intent of the conferees that a detailed series of conforming changes shall be made as soon as possible to the Internal Revenue Code, specifically subtitle K of the Internal Revenue Code of 1986 (as added by section 401(a) of the Health Insurance Portability and Accountability Act of 1996), in order to fully implement these provisions as part of chapter 100 of the Code.

TITLE VII - PARITY IN THE APPLICATION OF CERTAIN LIMITS TO ~~MENTAL~~ HEALTH BENEFITS

Amendment No. 118: ~~Inserts language proposed by the Senate regarding mental health parity, amended to delete the offsets and make other modifications.~~

The conference agreement includes the Senate amendment with modifications. It incorporates the requirement into the new part 7 of subtitle B of title I of ERISA and the new title XXVII of the Public Health Service Act as established by Public Law 104–191. The construction clause has been modified to state that nothing in this section shall be construed as—

(1) requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

(2) in the case of such a plan or coverage that provides such mental health benefits, as affecting the terms and conditions (including cost sharing, the 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 or coverage, except as specifically provided in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

This language affirms the intent of conferees that group health plans and issuers retain the flexibility, consistent with the requirements of the Act, to define the scope of

benefits, establish cost-sharing requirements, and to impose limits on hospital days and out-patient visits. Parity of mental health services with medical and surgical services defined under a group health plan is limited solely to any aggregate dollar life-time limit and any annual dollar limit under such a plan. The conference agreement clarifies that the requirements apply to each group health plan, and, in the case of a group health plan that offers two or more benefit packages, the parity requirements shall be applied separately with respect to each such option. In addition, the conference agreement applies an exemption to small employers as defined in the Health Insurance Portability and Accountability Act; adds certain definitions; and applies the requirements of the provision to group health plan years beginning on or after January 1, 1998. The agreement does not include the Senate language relating to effective dates for the Federal Employee Health Benefit Plan.

It is the intent of the conferees that a detailed series of conforming changes shall be made as soon as possible to the Internal Revenue Code, specifically subtitle K of the Internal Revenue Code of 1986 (as added by section 401(a) of the Health Insurance Portability and Accountability Act of 1996), in order to fully implement these provisions as part of chapter 100 of the Code.

The conferees intend that a limit be considered to apply to "substantially all medical and surgical benefits" if it applies to at least two-thirds of all the medical and surgical benefits covered under the group health plan's benefit package.

It is the intent of the conferees that, consistent with section 704 (redesignated as section 731) of ERISA and section 2723 of the Public Health Service Act, the application of the preemption provision should permit the operation of any State law or provision which requires more favorable treatment of mental health benefits under health insurance coverage than that required under this section.

## CONFERENCE TOTAL--WITH COMPARISONS

The total new budget (obligational) authority for the fiscal year 1997 recommended by the Committee of Conference, with comparisons to the fiscal year 1996 amount, the 1997 budget estimates, and the House and Senate bills for 1997 follow:

| | |
|---|---|
| New budget (obligational) authority, fiscal year 1996 | $ 82,442,966,000 |
| Budget estimates of new (obligational) authority, fiscal year 1997 | 87,820,371,000 |
| House bill, fiscal year 1997 | 83,995,260,000 |
| Senate bill, fiscal year 1997 | 84,810,153,000 |
| Conference agreement, fiscal year 1997 | 84,800,283,000 |
| Conference agreement compared with: | |
| New budget (obligational) authority, fiscal year 1996 | +2,357,317,000 |
| Budget estimates of new (obligational) authority, fiscal year 1997 | -3,020,088,000 |
| House bill, fiscal year 1997 | +805,023,000 |
| Senate bill, fiscal year 1997 | -9,870,000 |

Managers on the Part of the
HOUSE

JERRY LEWIS

[redacted]

BARBARA F. VUCANOVICH

JAMES T. WALSH

DAVID L. HOBSON

JOE KNOLLENBERG

RODNEY P. FRELINGHUYSEN

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BOB LIVINGSTON

LOUIS STOKES

ALAN B. MOLLOHAN

JIM CHAPMAN

MARCY KAPTUR

DAVID R. OBEY

Managers on the Part of the
SENATE

CHRISTOPHER S. BOND

CONRAD BURNS

TED STEVENS

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ROBERT F. BENNETT

BEN NIGHTHORSE CAMPBELL

MARK O. HATFIELD

BARBARA A. MIKULSKI

PATRICK J. LEAHY

J. BENNETT JOHNSTON

FRANK R. LAUTENBERG

J. ROBERT KERREY

ROBERT C. BYRD

AMENDMENT NUMBERED 118

That the House recede from its disagreement to the amendment of the Senate numbered 118, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert:

# TITLE VII—PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS

**SEC. 701. SHORT TITLE.**

This title may be cited as the "Mental Health Parity Act of 1996".

**SEC. 702. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a)) is amended by adding at the end the following new section:

**"SEC. 712. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.**

"(a) IN GENERAL.—

"(1) AGGREGATE LIFETIME LIMITS.—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 benefits—

"(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime

limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either—

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and

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surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

"(2) ANNUAL LIMITS.—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 benefits—

"(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either—

"(i) apply the applicable annual limit both to medical and surgical benefits to

which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

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"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting 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 or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) EXEMPTIONS.—

"(1) SMALL EMPLOYER EXEMPTION.—

"(A) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on

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business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(C) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this paragraph to an employer shall in-

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clude a reference to any predecessor of such employer.

"(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(e) DEFINITIONS.—For purposes of this section:

"(1) AGGREGATE LIFETIME LIMIT.—The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) ANNUAL LIMIT.—The term 'annual limit' means, with respect to benefits under a group health

plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

"(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) SUNSET.—This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act, as amended by section 602 of this Act, is amended by inserting after the item relating to section 711 the following new item:

"Sec. 712. Parity in the application of certain limits to mental health benefits.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

**SEC. 703. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.**

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a)) is amended by adding at the end the following new section:

**"SEC. 2705. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.**

"(a) IN GENERAL.—

"(1) AGGREGATE LIFETIME LIMITS.—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 benefits—

"(A) NO LIFETIME LIMIT.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) LIFETIME LIMIT.—If the plan or coverage includes an aggregate lifetime limit on

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substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either—

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the

weighted average of the aggregate lifetime limits applicable to such categories.

"(2) ANNUAL LIMITS.—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 benefits—

"(A) NO ANNUAL LIMIT.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) ANNUAL LIMIT.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either—

"(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

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"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) RULE IN CASE OF DIFFERENT LIMITS.—In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) CONSTRUCTION.—Nothing in this section shall be construed—

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of cov-

erage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) EXEMPTIONS.—

"(1) SMALL EMPLOYER EXEMPTION.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(2) INCREASED COST EXEMPTION.—This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section

shall be applied separately with respect to each such option.

"(e) DEFINITIONS.—For purposes of this section:

"(1) AGGREGATE LIFETIME LIMIT.—The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) ANNUAL LIMIT.—The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

"(4) MENTAL HEALTH BENEFITS.—The term 'mental health benefits' means benefits with respect

to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) SUNSET.—This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

; and the Senate agree to the same.

# 48 HOUR RULE

## I. 48 HOUR RULE

The "Newborns' and Mothers' Protection Act of 1996" will require health plans to allow all new mothers of newborns, at their option, to remain in the hospital for at least 48 hours following most normal deliveries.

## II. PURPOSE

Over the past two decades, the average length of stay for an uncomplicated childbirth has declined sharply. Today, a growing number of insurance companies are refusing to pay for anything more than a 24-hour stay, and as few as 8 hours.

## III. IMPACT

- This initiative will bring "peace of mind" to new mothers because they know they will not be discharged prematurely from the hospital.

## IV. SPECIFIC PROVISIONS

- Requires health plans to let mothers and newborns remain in the hospital for a minimum of 48 hours after a normal delivery and 96 hours after a Caesarean section.

- Shorter stays may be allowed if the attending health care provider, in consultation with the new mother, determines such a stay is appropriate.

- Requires follow-up care within 72 hours of discharge, if discharge occurs earlier than 48 hours after birth.

- The initiative will not pre-empt state legislation if states already require a minimum of 48 hour stays for normal deliveries (96 hours for Caesarean section) or meet guidelines established by the American College of Obstetricians or Gynecologists, the American Academy of Pediatrics, or certain other medical professional organizations.

## V. BACKGROUND

Senators Bradley, Frist and Kassebaum and Representative Dingell introduced the "Newborns' and Mothers' Health Protection Act" to allow all new mothers a minimum of 48 hours of care following most normal deliveries. The President, First Lady and members of the Administration challenged Congress to pass this legislation before they adjourned. In September, Congress responded to their challenge and included this legislation on the VA/HUD appropriations bill that they sent to the President for his signature.

## Statements In Support of the 48 Hour Rule

*"I urge members of Congress to move legislation forward as soon as possible that makes this protection for mothers and their children the law of the land. No insurance company should be free to make the final judgment about what is medically best for newborns and their mothers. That decision should be left up to doctors, nurses and mothers themselves."*

President Bill Clinton
May 11, 1996

*"We should protect mothers and newborn babies from being forced out of the hospital in less than 48 hours."*

President Bill Clinton
Democratic National Convention
August 30, 1996

*". . . the President is right to support a bill that would prohibit the practice of forcing mothers and babies to leave the hospital in less than 48 hours."*

Hillary Rodham Clinton
Democratic National Convention
August 28, 1996

*"That's why I'm supporting the legislation I mentioned, dealing with not forcing new mothers and their newborns out of the hospital."*

President Bill Clinton
September 5, 1996

*"We should enact bipartisan legislation to require health insurers to let all new mothers and their babies stay in the hospital at least 48 hours following normal deliveries."*

President Bill Clinton
September 11, 1996

# MENTAL HEALTH PARITY

## I. MENTAL HEALTH PARITY

This provision will prohibit insurers from setting separate lifetime and annual coverage limits for mental and physical illnesses.

## II. PURPOSE

In insurance plans today, there is widespread variation in lifetime and annual caps and in other aspects of mental health care coverage. Many of these plans discriminates against individuals diagnosed with mental illness. President Clinton believes that individuals with mental illness should be treated in the same manner as those with other medical disorders.

## III. IMPACT

This provision will provide more equitable treatment of mental health benefits under private health insurance plans.

## IV. SPECIFIC PROVISIONS

- This provision will require health plans that have a lifetime or annual limit on spending for medical or surgical services to include either mental health services in that total or have a separate limit for mental illnesses that is no more restrictive than the medical–surgical limit.

- The provision applies to health plans under the Federal Employee Benefit Health Plan (FEBHP) and the Employee Retirement Income Security Act (ERISA).

- Businesses with 50 or fewer employees are exempt from this provision.

- The provision does not require health plans to cover mental illness.

- The provision allows for separate co–payment, deductible and visit limits from mental health treatment.

- The provision will take effect January 1, 1998.

## V. BACKGROUND

The President has been a strong proponent of moving toward mental health parity. The President endorses reforms that will provide more equitable treatment of mental health benefits under private health insurance plans. The President stated his support for the Domenici/Wellstone compromise and expressed his disappointment that it was not included in the Kennedy/Kassebaum health insurance reform legislation. He also made a public commitment to work toward the passage of such legislation.

## Statements In Support of Mental Health Parity

*"I am writing to express the President's strong support for the alternative that has been proposed by Senator Domenici to prohibit health plans from establishing separate lifetime and annual limits for mental health benefits. People with mental illness have faced discrimination in health insurance coverage for far too long, and it is time we take steps to end this inequity..."*

Leon Panetta
July 30, 1996

*". . . I was disappointed that the mental health provision was taken out, [of the Kennedy/Kassebaum bill] and I certainly hope we can get it as soon as possible in the future. It should remain a high priority."*

President Bill Clinton
August 1, 1996

*"I wish this bill [Kennedy/Kassebaum] had contained the provision to eliminate the differential treatment of mental health coverage, or at least taken some positive steps in that direction."*

President Bill Clinton
August 21, 1996

*"We also have to find a way to provide access to mental health benefits and health insurance. It's a very important thing for our country."*

President Bill Clinton
August 27, 1996

*"We should ensure that the Domenici/Wellstone mental health parity compromise becomes law."*

President Bill Clinton
September 11, 1996

# CHILDREN OF VIETNAM VETERANS BORN WITH SPINA BIFIDA

## I. CHILDREN OF VIETNAM VETERANS BORN WITH SPINA BIFIDA

This legislation will authorize the Veterans' Administration to provide medical and rehabilitative training for children of Vietnam veterans who are born with the birth defect spina bifida.

## II. PURPOSE

Research has shown a positive link between spina bifida exposure to Agent Orange during service in Vietnam. The President strongly believes it is appropriate that we help children whose birth defects may be a result of their father's or mother's service to this country.

## III. IMPACT

- This initiative will provide assistance to at least 2,000 spina-bifida afflicted children of Vietnam veterans.
- This initiative will provide about $35 million in 1997 for treatment and vocational rehabilitation, with additional funding made available in the future.

## IV. SPECIFIC PROVISIONS

- Requires the Department of Veterans Affairs to furnish needed health care to a Vietnam veteran's child who is suffering from spina bifida.
- Provides treatment and vocational rehabilitation to eligible children.

## V. BACKGROUND

On May 20, 1996 you announced your intent to propose legislation to meet the needs of veterans' children afflicted with spina bifida -- the first time the offspring of American soldiers will receive benefits for combat-related health problems. The Congress responded to your challenge, through the leadership of Senator Daschle, Senator Rockefeller and Representative Evans, to pass legislation to authorize the Veterans' Administration to provide medical and rehabilitative training for children of Vietnam veterans who are born with the birth defect spina bifida.

## Statements In Support of Children of Vietnam Veterans Born with Spina Bifida

*"Our administration will also propose legislation to meet the needs of veterans' children afflicted with the birth defect, spina bifida -- the first time the offspring of American solders will receive benefits for combat-related health problems."*

President Bill Clinton
May 20, 1996

*"The President and I firmly believe that VA needs to be on the side of veterans and their children."*

Secretary Jesse Brown
May 25, 1996

*"It seems appropriate, therefore, and in the best interests of these children, that the same benefit of the doubt as is required to be given Vietnam veterans be given to their offspring, whose birth defects may be a result of their father's or mother's service to this country."*

Secretary Jesse Brown
July 25, 1996

*"We should act now to give the Veterans' Administration authority to help the children of Vietnam veterans who are born with the birth defect spina bifida."*

President Bill Clinton
September 11, 1996

# United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510–6300

TO: Chris Jennings

FR: David Nexon

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Statement of Conferees on Senate Amendment #118 to H.R. 3666 ("Mental Health Parity Act of 1996")

The conference agreement includes the Senate amendment with modifications. It incorporates the requirement into the new part 7 of subtitle B of title I of ERISA and the new title XXVII of the Public Health Service Act as established by Public Law 104–191. The construction clause has been modified to state that nothing in this section shall be construed as—

(1) requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

(2) in the case of such a plan or coverage that provides such mental health benefits, as affecting the terms and conditions (including cost sharing, the 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 or coverage, except as specifically provided in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

This language affirms the intent of conferees that group health plans and issuers retain the flexibility, consistent with the requirements of the Act, to define the scope of

benefits, establish cost-sharing requirements, and to impose limits on hospital days and out-patient visits. Parity of mental health services with medical and surgical services defined under a group health plan is limited solely to any aggregate dollar life-time limit and any annual dollar limit under such a plan. The conference agreement clarifies that the requirements apply to each group health plan, and, in the case of a group health plan that offers two or more benefit packages, the parity requirements shall be applied separately with respect to each such option. In addition, the conference agreement applies an exemption to small employers as defined in the Health Insurance Portability and Accountability Act; adds certain definitions; and applies the requirements of the provision to group health plan years beginning or or after January 1, 1998. The agreement does not include the Senate language relating to effective dates for the Federal Employee Health Benefit Plan.

It is the intent of the conferees that a detailed series of conforming changes shall be made as soon as possible to the Internal Revenue Code, specifically subtitle K of the Internal Revenue Code of 1986 (as added by section 401(a) of the Health Insurance Portability and Accountability Act of 1996), in order to fully implement these provisions as part of chapter 100 of the Code.

The conferees intend that a limit be considered to apply to "substantially all medical and surgical benefits" if it applies to at least two-thirds of all the medical and surgical benefits covered under the group health plan's benefit package.

It is the intent of the conferees that, consistent with section 704 (redesignated as section 731) of ERISA and section 2723 of the Public Health Service Act, the application of the preemption provision should permit the operation of any State law or provision which requires more favorable treatment of mental health benefits under health insurance coverage than that required under this section.

Filer: Hayes 55288

NEWBORNS: Substitute for page 6, line 19 through page 7 line 9 the following (and also in PHSA provisions):

"(f) PREEMPTION; EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

"(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 731(d)(1)) for a State that regulates such coverage that is described in any of the following subparagraphs:

"(A) Such State law requires such coverage to provide coverage for at least 48 hours of hospital length of stay following a normal vaginal delivery and at least 96 hours of hospital length of stay following a cesarian section.

"(B) Such State law requires such coverage to provide coverage for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or other established professional medical associations.

"(C) Such State law requires that such coverage for the hospital length of stay for ma-

tarnity and pediatric care may not be less than the coverage provided for in such guidelines unless such shorter coverage is at the recommendation of the attending provider in consultation with the mother.

"(2) CONSTRUCTION.—Section 731(a)(1) shall not be construed as superseding a State law described in paragraph (1).

Additional technical changes:

(1) MENTAL HEALTH PARITY (page 6, end of line 2): Aggregation rule should be applied to ERISA small employer provision. Add a new subparagraph (C):

"(C) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this paragraph to an employer shall in-

clude a reference to any predecessor of such employer.

(2) MENTAL HEALTH PARITY (page 6, line 13), should refer to "(c)(2)" rather than "(c)" [or should refer to "the requirements of this section" rather than "subsections (a) and (c)".]

(3) NEWBORNS. Strike page 7, lines 17 through 21 and conform succeeding provisions. [This would strike the following: Section 732(a) of such Act (as added by section 101 of the Health Insurance Portability and Accountability Act of 1996 and redesignated by the preceding provisions of this section) is amended by inserting "(other than section 711)" after "part".]