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. FINDINGS.—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.


(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.—

29 USC 1185.

29 USC 1191–

1191c.

Ante, p. 1939.

42 USC 300gg–4 note.

42 USC 201 note.

Newborns’ and Mothers’ Health Protection Act of 1996.

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“(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

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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
(3) Title I of such Act (as amended by section 101 of the Health Insurance Portability and Accountability Act of 1996 29 USC 1191a. 29 USC 1191. 110 STAT. 2938 PUBLIC LAW 104–204—SEPT. 26, 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—


Applicability.

29 USC 1191a.

29 USC 1181.

29 USC 1144.

29 USC 1136.

29 USC 1132.

29 USC 1024.

29 USC 1022.

29 USC 1021.

29 USC 1003.

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(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 NEWBORN.

“(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.—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.—

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(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:

42 USC 300gg–51.

42 USC 300gg–61—300gg–63.


42 USC 300gg–4 note.
(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))—
(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.

42 USC 300gg–4 note.

Applicability.
42 USC 300gg–44 note.
42 USC 300gg–62.
42 USC 300gg–61.
42 USC 300gg–44.

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(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—

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(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
(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).

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:

42 USC 201 note.
Mental Health
Parity Act of
1996.
'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.

29 USC 1185a.

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“(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 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.

“(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 include a reference to any predecessor of such employer.

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“(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 603 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:

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“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—

42 USC 300gg–5.

Applicability.

29 USC 1183b

note.

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“(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 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.—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.

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LEGISLATIVE HISTORY—H.R. 3666:
HOUSE REPORTS: Nos. 104–628 (Comm. on Appropriations) and 104–812 (Comm. of Conference).
SENATE REPORTS: No. 104–318 (Comm. on Appropriations).
CONGRESSIONAL RECORD, Vol. 142 (1996):
June 25, 26, considered and passed House.
Sept. 3–5, considered and passed Senate, amended.

Sept. 24, House agreed to conference report.

Sept. 25, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 32 (1996):

Sept. 26, Presidential remarks and statement.

“(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.

This Act may be cited as the “Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997”.

Approved September 26, 1996.