



Behavioral Health Care in H.R. 3200 and S. 1679

Ramya Sundararaman
Analyst in Public Health

October 6, 2009

Congressional Research Service

7-5700

www.crs.gov

R40847

CRS Report for Congress
Prepared for Members and Committees of Congress

R11173008

Summary

The 111th Congress has been considering various proposals that aim to improve the quality of and access to health care, including aspects of behavioral health care such as treatment for mental illnesses and substance abuse disorders. Behavioral health care-related proposals include requiring behavioral health coverage, expanding the provider workforce, improving behavioral health care coordination, and increasing funding for research on mental illness. Specifically, the proposals include provisions that would expand the scope of behavioral health parity, authorize grants to train behavioral health care providers, and provide for research on postpartum depression. Of these provisions, the one with the most far-reaching effect would possibly be that of expanding the scope of behavioral health parity.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), signed into law on October 3, 2008 (P.L. 110-343). This law expanded previous federal requirements for behavioral health coverage (which required parity for behavioral health coverage with that for physical illnesses in terms of annual and lifetime treatment benefits). Generally, the provisions of MHPAEA apply at the beginning of the plan year beginning after October 3, 2009. In April 2009, the Departments of Treasury, Labor, and Health and Human Services sought feedback from insurers and behavioral health providers about the costs and benefits of MHPAEA, impact on small employers, additional paperwork burdens, and regulatory concerns with regard to MHPAEA's various provisions. As of October 6, 2009, the departments have not published final regulations for the implementation of MHPAEA. Under H.R. 3200, which was ordered to be reported as amended by the House Committees on Ways and Means, Energy and Commerce, and Education and Labor, qualified health benefits plans (which would be required to provide behavioral health services) would be required to comply with the MHPAEA rules regarding the amount, duration, and scope of mental health and substance abuse benefits. This is also true of the minimum qualifying coverage specified in the Senate HELP bill, S. 1679. MHPAEA would also require carve-out programs (which are specialized managed care organizations that administer the behavioral health benefits for an insurance plan) to comply with the parity requirements in the same manner that the insurer would have been required.

Three other provisions in the health care reform proposals affect the behavioral health care system. First, there are provisions that aim to address the issue of behavioral health provider shortage by providing for the establishment of grant programs to train and educate such providers. Second, some provisions aim to address the issue of affordability and lack of coordination of behavioral health care through the establishment of federally qualified behavioral health centers and co-location of primary and specialty care services with behavioral health services. Third, a provision in the Energy and Commerce version of H.R. 3200 aims to address research needs in specialty areas of mental health care by authorizing studies on postpartum depression.

Contents

Introduction	1
Behavioral Health Parity	2
Overview of MHPAEA	2
Plans Covered by MHPAEA	3
Issues for Consideration	3
MHPAEA and Plans in H.R. 3200 and S. 1679	3
Effective Date for MHPAEA	4
Parity and Behavioral Health Carve-Outs	5
Other Behavioral Health Provisions in H.R. 3200 and S. 1679	5
Behavioral Health Provider Shortage	6
Provisions in the H.R. 3200 and S. 1679	6
Lack of Coordination of Behavioral Health Care	7
Provisions in the H.R. 3200 and S. 1679	7
Research on Postpartum Depression	8
Provision in the Energy and Commerce Version of H.R. 3200	8

Tables

Table A-1. Comparison of the Behavioral Health Provisions in H.R. 3200 and S. 1679	9
--	---

Appendixes

Appendix. Comparison of the Behavioral Health Provisions in H.R. 3200 and S. 1679	9
---	---

Contacts

Author Contact Information	9
----------------------------------	---

Introduction

The 111th Congress has been considering various proposals that aim to improve the quality of and access to physical and behavioral health care.¹ The proposals discussed in this report are contained in two bills that have been approved by committees in the 111th Congress. H.R. 3200 has been ordered to be reported, as amended, by the Committees on Ways and Means, Energy and Commerce, and Education and Labor.² An unnumbered bill was approved, as amended, by the Health, Education, Labor, and Pensions (HELP) Committee. The language in the unnumbered bill was introduced as S. 1679.³

In the past decade, four federal reports have offered insight into the nation's behavioral health care system and recommended a fundamental transformation of the system.⁴ While the current health reform proposals would not lead to the fundamental transformation recommended by these reports, they could have a significant effect on certain aspects of behavioral health care in the United States. The proposals include provisions that would expand the scope of behavioral health parity, authorize grants to train behavioral health care providers, and provide for certain mental health research needs. Of these provisions, the one with the most far-reaching effect would possibly be that of expanding the scope of behavioral health parity.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which was signed into law on October 3, 2008 (P.L. 110-343). This law expanded previous federal parity requirements for behavioral health coverage to require that the conditions of coverage for behavioral health, both in terms of the limitations placed on treatment (such as number of doctor visits) and the cost-sharing requirements (such as deductibles), can be no more restrictive than for coverage of medical and surgical benefits. A partial federal mental health parity law, which requires parity only for annual and lifetime limits in mental health coverage, has been in existence since 1996.

This report provides an overview of the behavioral health provisions in the committee-approved health care reform proposals (H.R. 3200 and S. 1679). Since parity is potentially the most far-reaching provision of those currently being considered, this report focuses in greater depth on

¹ Behavioral health care includes treatment for mental illnesses and substance abuse disorders.

² For more information on the provisions in H.R. 3200, see (1) CRS Report R40745, *Public Health, Workforce, Quality, and Other Provisions in H.R. 3200*, coordinated by C. Stephen Redhead; (2) CRS Report R40724, *Private Health Insurance Provisions of H.R. 3200*, by Hinda Chaikind et al.; (3) CRS Report R40804, *Medicare Program Changes in H.R. 3200, America's Affordable Health Choices Act of 2009*, coordinated by Sibyl Tilson; and (4) CRS Report R40821, *Medicaid and Children's Health Insurance Program (CHIP) Provisions in America's Affordable Health Choices Act of 2009 (H.R. 3200)*, by Evelyne P. Baumrucker, Cliff Binder, and Elicia J. Herz.

³ For more information on the provisions in S. 1679, see (1) CRS Report R40831, *Public Health, Workforce, Quality, and Other Provisions in the Affordable Health Choices Act (S. 1679)*, coordinated by Kirsten J. Colello and C. Stephen Redhead, and (2) CRS Report R40842, *Community Living Assistance Services and Supports (CLASS) Provisions in the Affordable Health Choices Act (S. 1679)*, by Janemarie Mulvey.

⁴ The four reports are (1) National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, 2008, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>; (2) United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; (3) Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005; and (4) The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

health reform issues related to MHPAEA. It provides background on MHPAEA, clarifies the plans that MHPAEA applies to and those exempt from it, and analyzes some of the issues that have arisen or may arise as Congress considers the role of behavioral health parity in health care reform. A comparison of the behavioral health provisions in the two bills is included in the **Appendix**. This report will be updated as necessary, as the health reform discussion continues.

Behavioral Health Parity

On October 3, 2008, President George W. Bush signed into law P.L. 110-343, which provided authority for the federal government to purchase and insure certain types of troubled assets to provide stability to the economy and financial system. MHPAEA was incorporated as Division C of P.L. 110-343 as Title V, Subtitle B. The MHPAEA amends the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC) to require parity for behavioral health coverage.⁵ This section summarizes the key provisions of MHPAEA and discusses key issues at the intersection of health care reform and behavioral health parity.

Overview of MHPAEA

MHPAEA's provisions require group health plans that provide behavioral health coverage to provide it on par with the medical and surgical benefits that they provide, with respect to certain aspects of the coverage. Specifically, MHPAEA requires plans to ensure that

- the financial requirements (including deductibles, copayments, coinsurance, and out-of-pocket expenses) applicable to the behavioral health benefits are no more restrictive than those applied to substantially all of the plan's medical and surgical benefits;
- there are no separate cost-sharing requirements that are applicable only to behavioral health benefits;
- the treatment limitations (including limits on the frequency of treatment, number of visits, days of coverage, or the scope or duration of treatment) applicable to behavioral health benefits are no more restrictive than those applied to substantially all of the plan's medical and surgical benefits; and
- there are no separate treatment limitations that are applicable only to behavioral health benefits.⁶

In April 2009, the Departments of Treasury, Labor, and Health and Human Services published a notice in the *Federal Register* requesting responses from insurance companies and behavioral health providers.⁷ The Departments sought feedback about the costs and benefits of MHPAEA,

⁵ ERISA regulates employee benefit plans, including employer-sponsored group health plans; the PHSA applies to insurance companies and managed care organizations, and to nonfederal government health plans; and the IRC covers group health plans (using a slightly broader definition than ERISA).

⁶ For more information on MHPAEA, see CRS Report RS22958, *Mental Health Parity: An Overview*, by Ramya Sundararaman.

⁷ Department of Treasury, Department of Labor, Department of Health and Human Services, "Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008," 74 *Federal Register* (continued...)

impact on small employers, additional paperwork burdens, and regulatory concerns with regard to MHPAEA's various provisions. As of October 6, 2009, the departments have not published final regulations for the implementation of MHPAEA.

Plans Covered by MHPAEA

The provisions of MHPAEA apply only to group plans that choose to offer behavioral health coverage. In addition, MHPAEA allows insurers to cover only some behavioral health conditions of their choosing. By amending three federal statutes (i.e., ERISA, the PHSA, and the IRC), the MHPAEA standards apply to a range of group health plans, as well as state-licensed health insurance organizations. The ERISA provisions apply to most group plans sponsored by private-sector employers and unions. The IRC provisions, which cover ERISA plans plus church-sponsored plans, permit the Internal Revenue Service to assess tax penalties on employers that do not comply with the MHPAEA requirements. The PHSA provisions apply to group health insurance issuers and some public-sector group health plans. Although states have taken on primary responsibility for the enforcement of many of the mandates as they apply to health insurers, other enforcement actions are available to the Secretaries of the Department of Labor, Department of Health and Human Services, and Treasury.

There are some additional provisions exempting plans from complying with MHPAEA. The provisions exempt small group plans, which are group health plans sponsored by employers with 50 or fewer employees. The law also allows health plans that experience a cost increase of at least 1% (2% in the first year of MHPAEA being in effect) as a result of complying with this Act to be exempt from parity requirements for one year. Self-insured state and local government health plans may elect exemption from the MHPAEA.

Issues for Consideration

When insurance provisions of the health reform bills are discussed, questions may arise about potential implications for behavioral health coverage. Lawmakers may want to assess whether the proposals ensure or expand or otherwise affect access to quality behavioral health care. In broad terms, questions that have been and may be raised pertain to (1) the effective date for MHPAEA and how that affects or is affected by the health reform bills, (2) the effect of the provisions of MHPAEA on those of the health reform bills, and (3) the use of behavioral health carve-outs. This section analyzes and provides clarification on these issues.

MHPAEA and Plans in H.R. 3200 and S. 1679

Neither H.R. 3200 nor S. 1679 would directly amend the MHPAEA. However, MHPAEA provisions would affect the scope of certain provisions in the health reform bills. There are two aspects to consider in this potential interaction between MHPAEA and the health reform bills. First, H.R. 3200 and S. 1679 would require that "qualified"⁸ plans include behavioral health

(...continued)

Register, April 28, 2009.

⁸ A plan is considered "qualified" in the health reform proposals when they meet certain requirements, one of which is provision of behavioral health services.

benefits and that these plans comply with the requirements of MHPAEA. This would result in plans being mandated to provide behavioral health benefits on par with medical and surgical benefits. Second, while the health reform bills would apply to individual and group plans, the provisions of MHPAEA apply specifically to group plans. This would raise the issue of whether only the qualified group insurance plans would be required to provide parity behavioral health benefits, or whether the requirement would also extend to individual plans.

H.R. 3200 would require qualified health benefits plans (including the public health insurance option) to comply with the existing parity statutes in the PHSA regarding the amount, duration, and scope of mental health and substance abuse benefits, as outlined earlier in this report.⁹ Similarly, S. 1679 would require qualified health benefits plans (including the public health insurance option) to comply with existing mental health parity rules in the PHSA, in the same manner and to the same extent as health insurance issuers and group health plans.¹⁰

The existing parity rules in the PHSA do not mandate that plans provide behavioral health coverage. However, the essential benefits package outlined in the health care reform bills is required to include behavioral health services. Thus, in general, plans that comply with the qualifying standards set forth in the health care reform bills, and hence include services required in the essential benefits package, would be required to offer full parity for mental health and substance abuse treatment benefits.

Effective Date for MHPAEA

As mentioned above, certain plans would be required to comply with MHPAEA once the health care reform provisions are enacted. This section addresses the issue of *when* these plans would be required to comply with MHPAEA.

Generally, the provisions of MHPAEA apply at the beginning of the plan year beginning after October 3, 2009. In the case of most health insurance plans, which are based on the calendar year, the effective date will be January 1, 2010. There is an exemption to the general effective date mentioned above. For group health plans that fall under collective bargaining agreements that were ratified before October 3, 2008, there is a special effective date rule. For such plans, MHPAEA's requirements will apply to plan years beginning on the later of the following two dates: (1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008) or (2) January 1, 2010.

The provisions in H.R. 3200 and S. 1679 may expand the scope of MHPAEA to include more plans, as described below. Generally, the newly included plans would be required to comply with MHPAEA at the beginning of their next plan year. In addition to the special exceptions noted

⁹ Under H.R. 3200, qualified health benefits plans are plans available in 2013 (and after) that meet certain requirements, including those affecting behavioral health discussed in this report. Some plans may be deemed "acceptable" while not being "qualified" (such as, grandfathered plans). For more information, see CRS Report R40724, *Private Health Insurance Provisions of H.R. 3200*, by Hinda Chaikind et al.

¹⁰ Although the term does not appear in S. 1679, "qualified health benefits plan" is used in this report as a term similar to its use in H.R. 3200. In particular, it refers to private health insurance that is "qualifying coverage" because it "meets or exceeds the criteria for minimum qualifying coverage," per Sec.3116(a)(5)(B)(ii).

above, the effective date for these newly included plans to comply with MHPAEA may vary depending on the date that the parity provisions in health reform legislation are enacted.

Parity and Behavioral Health Carve-Outs

“Carve-out” programs are frequently used by insurers to manage behavioral health benefits. These programs have been criticized by some, as detailed below. MHPAEA allows the use of carve-out programs; the health reform proposals are silent on whether plans may use them.

Medicaid and many private insurers contract with specialized managed care organizations to provide behavioral health benefits. These “carve-out” programs, which transfer the responsibility for behavioral health services to specialty behavioral health organizations, have become increasingly attractive as a cost-containment strategy.¹¹ They also transfer the risk associated with the cost of providing behavioral health care to these behavioral health organizations. While carve-outs may be an attractive option for insurers, the provider community is opposed to them for a number of reasons. For example, carve-outs may make coordination between physical and mental health services difficult; carve-outs may also reinforce the stigmatization of behavioral health conditions by separating them out.¹²

MHPAEA requires carve-out programs to comply with the parity requirements in the same manner that the insurer would have been required. However, MHPAEA does not prohibit medical management of benefits. Hence, the carve-out programs could impose additional requirements, such as referrals or pre-approvals, in order to contain costs associated with providing behavioral health treatment.

H.R. 3200 and S. 1679 would require all qualified plans to provide behavioral health coverage and provide such coverage on par with coverage for physical health.¹³ When insurers who have not offered behavioral health coverage in the past are required to provide parity behavioral health coverage, they may use carve-out programs in an attempt to shift the risk associated with the cost of providing such care.¹⁴ The health care reform proposals do not directly address the use of behavioral health carve-outs by health insurers.

Other Behavioral Health Provisions in H.R. 3200 and S. 1679

National reports on the U.S. behavioral health care system have identified a number of issues, including provider shortage, lack of coordination between behavioral health and other care, and

¹¹ Wayne R., Daughtery J., and Meador K., “Effect of a Mental Health “Carve-Out” Program on the Continuity of Antipsychotic Therapy,” *New England Journal of Medicine*, vol. 348 (2003).

¹² AMA House of Delegates, *Elimination of Mental Health and Chemical Dependency Carve-Outs*, American Medical Association, Resolution 702, October 2000.

¹³ Sec. 114 and 122 of H.R. 3200 and Sec. 142 of S. 1679.

¹⁴ Zuvekas S. et al., “The Impacts Of Mental Health Parity And Managed Care In One Large Employer Group,” *Health Affairs*, vol. 21, no. 3, (2002).

lack of research in certain areas of behavioral health.¹⁵ This section outlines these three issues and analyzes how the health reform proposals may address those issues.

Behavioral Health Provider Shortage

There is a shortage of behavioral health care providers, and this shortage is notably severe in rural areas.¹⁶ Some provisions in the health reform proposals would address this shortage by providing for increased education and training resources. The grant programs established by these provisions could lead to an increase in the number of behavioral health care providers in rural and other areas that are experiencing a shortage of such providers.

The Health Resources and Services Administration (HRSA), an agency within the Department of Health and Human Services (HHS), designates geographical areas with less than one behavioral health provider per 10,000 population as a Health Professional Shortage Area (HPSA) for behavioral health. In 2008, 66% of HPSAs for behavioral health were in rural areas. Also that year, there were 3,059 HPSAs for behavioral health, with a total of 77 million people living in these areas. According to HRSA, it would take 5,145 practitioners to meet the need for behavioral health providers.¹⁷ Due to the lack of specialty behavioral health providers in rural areas, primary care providers who practice in nonmetropolitan areas play a large role in behavioral health care.

Provisions in the H.R. 3200 and S. 1679

Provisions in both bills would provide for grants to train behavioral health providers and give preference to grant applicants who would increase the supply of behavioral health providers in rural areas and other areas with a shortage of such providers. While the health reform proposals authorize funding for these grants, their implementation would depend on funding from relevant appropriations committees.

A provision in H.R. 3200 would require grants to a number of organizations, such as institutions of higher education, hospitals, and non-profit entities, to support interdisciplinary mental and behavioral health training programs.¹⁸

A provision in S. 1679 would authorize grants to institutions of higher education to support the recruitment and education of students in social work programs, interdisciplinary psychology training programs, and child and adolescent mental health training programs. The provision

¹⁵ The reports include (1) National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, 2008, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>; (2) United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>; (3) Institute of Medicine Committee on Quality of Health Care in America, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, 2005; and (4) The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

¹⁶ The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

¹⁷ Health Resources and Services Administration, <http://bhpr.hrsa.gov/shortage/index.htm>.

¹⁸ Sec. 2522 of H.R. 3200.

would also support state-licensed mental health organizations to train paraprofessional child and adolescent mental health workers.¹⁹

Lack of Coordination of Behavioral Health Care

Experts report that there is often lack of coordination of behavioral health care with other health care that is provided in various settings.²⁰ In addition, individuals with behavioral health conditions are faced with problems of affordability of care and differences between payment systems.²¹ Provisions in the health reform proposals would enable the provision of coordinated and affordable behavioral health care at federally qualified behavioral health centers, or by co-locating primary and specialty care services with behavioral health services.

According to the Office of the Surgeon General, effective functioning of the behavioral health care system requires connections and coordination among public and private sectors, various specialty services, and a range of institutions in housing, criminal justice, and education.²² Individuals with mental illnesses may receive social services and general health care services from various agencies or providers. Lack of effective communication between these service providers could result in missed opportunities to ensure that individuals with behavioral health conditions, who may come in contact with any of these systems, get routed to appropriate care. The Surgeon General's report on mental health asserts that such coordination at the systems level, or with financial mechanisms, is necessary to ensure that an individual, whose cognitive ability may be diminished as a result of his or her mental illness, is able to navigate the system's bureaucracy and receive the mental health care he or she needs.

Individuals often pay for the behavioral health care they receive with more than one funding source, and different payers may require different processes for seeking and paying for care. Some providers may not accept public and private mechanisms for financing behavioral health care. The situation is further complicated because the mental functioning of an individual needing this care is often reduced. Hence, without coordination, care can soon become fragmented, creating barriers to access.

Provisions in the H.R. 3200 and S. 1679

Provisions in both bills aim to provide coordinated and affordable behavioral health care. While H.R. 3200 would establish federally qualified behavioral health centers (FQBHCs) nationwide to provide coordinated and affordable care, S. 1679 would fund demonstration grants to assess the effectiveness of co-locating specialty and mental health care in community-based centers.

¹⁹ Sec. 436 of S. 1679.

²⁰ The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

²¹ Different payment systems for behavioral health care may have different managed care requirements, such as pre-approvals and co-payments. Payers may also differ in the process they use to process claims and reimburse for behavioral health care.

²² United States Public Health Service Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

A provision in H.R. 3200 would establish (FQBHCs), which would be similar to federally qualified health centers.²³ These centers would provide affordable, accessible and coordinated care to individuals with behavioral health conditions.²⁴

A provision in S. 1679 would create a new grant program—Grants for Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings—which would require the funding of demonstration projects for providing coordinated care to individuals with mental illness and co-occurring primary care conditions and chronic disease, through the co-location of primary and specialty care in community-based mental health settings.²⁵

On the one hand, depending on the resources appropriated to FQBHCs, H.R. 3200 could address the issues of coordination of behavioral health care and affordability. On the other hand, the demonstration grant that would be created by S. 1679 would determine the effectiveness of the strategy of co-locating care before additional resources are used in its widespread implementation.

Research on Postpartum Depression

Significant advances have been made in the general understanding and treatment of mental illness. Despite these advances, experts believe that many Americans are not benefiting from improved mental health care.²⁶ According to experts, one of the reasons for this is a shortage of research in a number of specialty areas of mental health care.²⁷ One specialty area of mental health care—postpartum depression—is addressed in H.R. 3200; none are specifically addressed in S. 1679.

Provision in the Energy and Commerce Version of H.R. 3200

A provision in the Energy and Commerce version of H.R. 3200 would require a study on the benefits of screening for postpartum conditions, which affects 13% to 20% of women after birth or miscarriage.²⁸ It would be the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study on the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways.²⁹ It would provide for research on the causes of, and treatments for, postpartum conditions, including conducting basic research and epidemiological studies, improving screening and diagnostic techniques, and developing information and education programs.

²³ Federally Qualified Health Centers are community-based organizations that are funded by HRSA to provide comprehensive medical care to persons of all ages, regardless of their ability to pay. For more information about these centers, see CRS Report RL32046, *Federal Health Centers Program*, by Barbara English.

²⁴ Sec. 2513 of H.R. 3200.

²⁵ Sec. 176 of S. 1679.

²⁶ Wang, P. S., Demler, O., and Kessler, R. C., “Adequacy of treatment for serious mental illness in the United States,” *American Journal of Public Health*, vol. 92 (2002).

²⁷ The President’s New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, July 2003, <http://www.mentalhealthcommission.gov/reports/reports.htm>.

²⁸ Mancini F., Carlson C., and Albers L., “Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice,” *Journal of Midwifery & Women’s Health*, vol. 52, no. 5 (2007).

²⁹ Sec. 2530 of H.R. 3200.

Appendix. Comparison of the Behavioral Health Provisions in H.R. 3200 and S. 1679

Table A-1. Comparison of the Behavioral Health Provisions in H.R. 3200 and S. 1679

Issue	H.R. 3200	S. 1679
Behavioral Health Parity	Would require all qualifying plans to provide behavioral health coverage on par with that for physical health.	Same as H.R. 3200.
Provider Shortage	Would provide for training grants to increase supply of behavioral health care providers in shortage areas.	Same as H.R. 3200.
Lack of Coordination and Affordability	Would establish FQBHCs to provide coordinated and affordable behavioral health care.	Would provide for demonstration projects to determine the effectiveness of co-locating specialty and behavioral health care in community-based centers.
Research on Postpartum Depression	Would requires research on post-partum depression. ^a	No comparable provision.

Source: Compiled by CRS using legislative language in H.R. 3200 and S. 1679.

- a. This provision exists only in the Energy and Commerce version of H.R. 3200.

Author Contact Information

Ramya Sundararaman
Analyst in Public Health
rsundararaman@crs.loc.gov, 7-7285