(126th General Assembly)
(Amended Substitute Senate Bill Number 116)

AN ACT

To amend sections 1739.05, 1751.01, 1751.02, 3923.28, 3923.30, and 3923.51 and to enact sections 3923.281 and 3923.282 of the Revised Code to prohibit, subject to certain exceptions, discrimination in group health care policies, contracts, and agreements in the coverage provided for the diagnosis, care, and treatment of biologically based mental illnesses, and to prohibit for ninety days, the establishment of special hospitals in counties with a population of more than one hundred forty thousand but less than one hundred fifty thousand individuals.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1739.05, 1751.01, 1751.02, 3923.28, 3923.30, and 3923.51 be amended and sections 3923.281 and 3923.282 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to

3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1751.01. As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary:

~~(1)~~(a) Physician's services, except when such services are supplemental under division (B) of this section;

~~(2)~~(b) Inpatient hospital services;

~~(3)~~(c) Outpatient medical services;

~~(4)~~(d) Emergency health services;

~~(5)~~(e) Urgent care services;

~~(6)~~(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

~~(7)~~(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care.

"Basic health care services" does not include experimental procedures.

~~A~~ Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the

federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the department of job and family services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

~~(1)~~(a) Services of facilities for intermediate or long-term care, or both;

~~(2)~~(b) Dental care services;

~~(3)~~(c) Vision care and optometric services including lenses and frames;

~~(4)~~(d) Podiatric care or foot care services;

~~(5)~~(e) Mental health services ~~including psychological services,~~ excluding diagnostic and treatment services for biologically based mental illnesses;

~~(6)~~(f) Short-term outpatient evaluative and crisis-intervention mental health services;

~~(7)~~(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

~~(8)~~(h) Home health services;

~~(9)~~(i) Prescription drug services;

~~(10)~~(j) Nursing services;

~~(11)~~(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

~~(12)~~(l) Physical therapy services;

~~(13)~~(m) Chiropractic services;

~~(14)~~(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B)~~(1) to (13)~~ of this section, when

provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

~~(E)~~(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

~~(F)~~(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

~~(G)~~(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

~~(H)~~(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

~~(I)~~(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

~~(J)~~(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

~~(K)~~(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, mental retardation, intermediate care, or skilled nursing services.

~~(L)~~(M) "Health care services" means basic, supplemental, and specialty health care services.

~~(M)~~(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

~~(N)~~(O) "Health insuring corporation" means a corporation, as defined in

division ~~(G)~~(H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

~~(O)~~(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

~~(P)~~(Q) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

~~(Q)~~(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

~~(R)~~(S)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows

enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

~~(S)~~(T) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

~~(T)~~(U) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

~~(U)~~(V) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

~~(V)~~(W) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

~~(W)~~(X) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse midwives, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health

personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

~~(X)~~(Y) "Provider sponsored organization" means a corporation, as defined in division ~~(G)~~(H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

~~(Y)~~(Z) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

~~(Z)~~(AA) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

~~(AA)~~(BB) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.02. (A) Notwithstanding any law in this state to the contrary, any corporation, as defined in section 1751.01 of the Revised Code, may apply to the superintendent of insurance for a certificate of authority to establish and operate a health insuring corporation. If the corporation applying for a certificate of authority is a foreign corporation domiciled in a state without laws similar to those of this chapter, the corporation must form a domestic corporation to apply for, obtain, and maintain a certificate of authority under this chapter.

(B) No person shall establish, operate, or perform the services of a health insuring corporation in this state without obtaining a certificate of authority under this chapter.

(C) Except as provided by division (D) of this section, no political subdivision or department, office, or institution of this state, or corporation

formed by or on behalf of any political subdivision or department, office, or institution of this state, shall establish, operate, or perform the services of a health insuring corporation. Nothing in this section shall be construed to preclude a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, or a public entity formed by or on behalf of any of these boards, from using managed care techniques in carrying out the board's or public entity's duties pursuant to the requirements of Chapters 307., 329., 340., and 5126. of the Revised Code. However, no such board or public entity may operate so as to compete in the private sector with health insuring corporations holding certificates of authority under this chapter.

(D) A corporation formed by or on behalf of a publicly owned, operated, or funded hospital or health care facility may apply to the superintendent for a certificate of authority under division (A) of this section to establish and operate a health insuring corporation.

(E) A health insuring corporation shall operate in this state in compliance with this chapter and Chapter 1753. of the Revised Code, and with sections 3702.51 to 3702.62 of the Revised Code, and shall operate in conformity with its filings with the superintendent under this chapter, including filings made pursuant to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised Code.

(F) An insurer licensed under Title XXXIX of the Revised Code need not obtain a certificate of authority as a health insuring corporation to offer an open panel plan as long as the providers and health care facilities participating in the open panel plan receive their compensation directly from the insurer. If the providers and health care facilities participating in the open panel plan receive their compensation from any person other than the insurer, or if the insurer offers a closed panel plan, the insurer must obtain a certificate of authority as a health insuring corporation.

(G) An intermediary organization need not obtain a certificate of authority as a health insuring corporation, regardless of the method of reimbursement to the intermediary organization, as long as a health insuring corporation or a self-insured employer maintains the ultimate responsibility to assure delivery of all health care services required by the contract between the health insuring corporation and the subscriber and the laws of this state or between the self-insured employer and its employees.

Nothing in this section shall be construed to require any health care facility, provider, health delivery network, or intermediary organization that

contracts with a health insuring corporation or self-insured employer, regardless of the method of reimbursement to the health care facility, provider, health delivery network, or intermediary organization, to obtain a certificate of authority as a health insuring corporation under this chapter, unless otherwise provided, in the case of contracts with a self-insured employer, by operation of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended.

(H) Any health delivery network doing business in this state, including any health delivery network that is functioning as an intermediary organization doing business in this state, that is not required to obtain a certificate of authority under this chapter shall certify to the superintendent annually, not later than the first day of July, and shall provide a statement signed by the highest ranking official which includes the following information:

(1) The health delivery network's full name and the address of its principal place of business;

(2) A statement that the health delivery network is not required to obtain a certificate of authority under this chapter to conduct its business.

(I) The superintendent shall not issue a certificate of authority to a health insuring corporation that is a provider sponsored organization unless all health care plans to be offered by the health insuring corporation provide basic health care services. Substantially all of the physicians and hospitals with ownership or control of the provider sponsored organization, as defined in ~~division (X) of~~ section 1751.01 of the Revised Code, shall also be participating providers for the provision of basic health care services for health care plans offered by the provider sponsored organization. If a health insuring corporation that is a provider sponsored organization offers health care plans that do not provide basic health care services, the health insuring corporation shall be deemed, for purposes of section 1751.35 of the Revised Code, to have failed to substantially comply with this chapter.

Except as specifically provided in this division and in division (A) of section 1751.28 of the Revised Code, the provisions of this chapter shall apply to all health insuring corporations that are provider sponsored organizations in the same manner that these provisions apply to all health insuring corporations that are not provider sponsored organizations.

(J) Nothing in this section shall be construed to apply to any multiple employer welfare arrangement operating pursuant to Chapter 1739. of the Revised Code.

(K) Any person who violates division (B) of this section, and any health delivery network that fails to comply with division (H) of this section, is

subject to the penalties set forth in section 1751.45 of the Revised Code.

Sec. 3923.28. (A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1979, and that provides coverage for mental or emotional disorders, shall provide benefits for services on an outpatient basis for each eligible person under the policy who resides in this state for mental or emotional disorders, or for evaluations, that are at least equal to five hundred fifty dollars in any calendar year or twelve-month period. The services shall be legally performed by or under the clinical supervision of a ~~licensed~~ physician ~~or licensed~~ authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health, whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the joint commission on accreditation of healthcare organizations, the council on accreditation for children and family services, the rehabilitation accreditation commission, or, until two years after ~~the effective date of this amendment~~ June 6, 2001, certified by the department of mental health as being in compliance with standards established under division (H) of section 5119.01 of the Revised Code.

(B) Outpatient benefits offered under division (A) of this section shall be subject to reasonable contract limitations and may be subject to reasonable deductibles and co-insurance costs. Persons entitled to such benefit under more than one service or insurance contract may be limited to a single five-hundred-fifty-dollar outpatient benefit for services under all contracts.

(C) In order to qualify for participation under division (A) of this section, every facility specified in such division shall have in effect a plan for utilization review and a plan for peer review and every person specified in such division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services.

(D) Nothing in this section shall be construed to require an insurer to pay benefits which are greater than usual, customary, and reasonable.

(E)(1) Services performed under the clinical supervision of a ~~licensed~~

~~physician or licensed psychologist~~ health care professional identified in division (A) of this section, in order to be reimbursable under the coverage required in division (A) of this section, shall meet both of the following requirements:

(a) The services shall be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed;

(b) The plan shall be reviewed and approved by ~~a licensed physician or licensed psychologist~~ the health care professional every three months.

(2) Payment of benefits for services reimbursable under division (E)(1) of this section shall not be restricted to services described in the treatment plan or conditioned upon standards of clinical supervision that are more restrictive than standards of a ~~licensed physician or licensed psychologist~~ health care professional described in division (A) of this section, which at least equal the requirements of division (E)(1) of this section.

(F) The benefits provided by this section for mental and emotional disorders shall not be reduced by the cost of benefits provided pursuant to section 3923.281 of the Revised Code for diagnostic and treatment services for biologically based mental illnesses. This section does not apply to benefits for diagnostic and treatment services for biologically based mental illnesses.

Sec. 3923.281. (A) As used in this section:

(1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(2) "Policy of sickness and accident insurance" has the same meaning as in section 3923.01 of the Revised Code, but excludes any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of not longer than six months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; and any policy that provides coverage to beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, as provided by the Ohio department of job and family services under Chapter 5111. of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (E) of this section, every group policy of sickness and accident insurance shall provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the policy of sickness and accident insurance for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply:

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

(C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles.

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions:

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services;

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses;

(3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary;

(4) Enforcing the terms and conditions of a policy of sickness and accident insurance.

(E) An insurer that offers a group policy of sickness and accident insurance is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses pursuant to division (B) of this section if all of the following apply:

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(a) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

Sec. 3923.282. (A) As used in this section:

(1) "Biologically based mental illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(2) "Plan of health coverage" includes any private or public employer group self-insurance plan that provides payment for health care benefits for other than specific diseases or accidents only, which benefits are not provided by contract with a sickness and accident insurer or health insuring corporation.

(B) Notwithstanding section 3901.71 of the Revised Code, and subject to division (F) of this section, each plan of health coverage shall provide

benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, and shall provide benefits no less extensive than, those provided under the plan of health coverage for the treatment and diagnosis of all other physical diseases and disorders, if both of the following apply:

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

(C) Division (B) of this section applies to all coverages and terms and conditions of the plan of health coverage, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles.

(D) This section does not apply to a plan of health coverage if federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plans. This section does not apply to long-term care, hospital indemnity, disability income, or medicare supplement plans of health coverage, or to any other supplemental benefit plans of health coverage.

(E) Nothing in this section shall be construed as prohibiting an employer from taking any of the following actions in connection with a plan of health coverage:

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services;

(2) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary;

(3) Enforcing the terms and conditions of a plan of health coverage.

(F) An employer that offers a plan of health coverage is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses in combination with benefits for the treatment and diagnosis of all

other physical diseases and disorders as described in division (B) of this section if both of the following apply:

(1) The employer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

(2) The superintendent of insurance determines from the documentation and opinion submitted pursuant to division (F) of this section, that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

Sec. 3923.30. Every person, the state and any of its instrumentalities, any county, township, school district, or other political subdivisions and any of its instrumentalities, and any municipal corporation and any of its instrumentalities, which provides payment for health care benefits for any of its employees resident in this state, which benefits are not provided by contract with an insurer qualified to provide sickness and accident insurance, or a health insuring corporation, shall include the following benefits in its plan of health care benefits commencing on or after January 1, 1979:

(A) If such plan of health care benefits provides payment for the treatment of mental or nervous disorders, then such plan shall provide benefits for services on an outpatient basis for each eligible employee and dependent for mental or emotional disorders, or for evaluations, that are at least equal to the following:

(1) Payments not less than five hundred fifty dollars in a twelve-month period, for services legally performed by or under the clinical supervision of a ~~licensed~~ physician ~~or a licensed~~ authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a professional clinical counselor, professional counselor, or independent social worker licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist licensed under Chapter 4723. of the Revised Code

whose nursing specialty is mental health, whether performed in an office, in a hospital, or in a community mental health facility so long as the hospital or community mental health facility is approved by the joint commission on accreditation of healthcare organizations, the council on accreditation for children and family services, the rehabilitation accreditation commission, or, until two years after ~~the effective date of this amendment~~ June 6, 2001, certified by the department of mental health as being in compliance with standards established under division (H) of section 5119.01 of the Revised Code;

(2) Such benefit shall be subject to reasonable limitations, and may be subject to reasonable deductibles and co-insurance costs.

(3) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and effective and efficient utilization of available health facilities and services.

(4) Such payment for benefits shall not be greater than usual, customary, and reasonable.

(5)(a) Services performed by or under the clinical supervision of a ~~licensed physician or licensed psychologist~~ health care professional identified in division (A)(1) of this section, in order to be reimbursable under the coverage required in division (A) of this section, shall meet both of the following requirements:

(i) The services shall be performed in accordance with a treatment plan that describes the expected duration, frequency, and type of services to be performed;

(ii) The plan shall be reviewed and approved by ~~a licensed physician or licensed psychologist~~ the health care professional every three months.

(b) Payment of benefits for services reimbursable under division (A)(5)(a) of the section shall not be restricted to services described in the treatment plan or conditioned upon standards of a licensed physician or licensed psychologist, which at least equal the requirements of division (A)(5)(a) of this section.

(B) Payment for benefits for alcoholism treatment for outpatient, inpatient, and intermediate primary care for each eligible employee and dependent that are at least equal to the following:

(1) Payments not less than five hundred fifty dollars in a twelve-month period for services legally performed by or under the clinical supervision of a ~~licensed physician or licensed psychologist~~ health care professional

identified in division (A)(1) of this section, whether performed in an office, or in a hospital or a community mental health facility or alcoholism treatment facility so long as the hospital, community mental health facility, or alcoholism treatment facility is approved by the joint commission on accreditation of hospitals or certified by the department of health;

(2) The benefits provided under this division shall be subject to reasonable limitations and may be subject to reasonable deductibles and co-insurance costs.

(3) A ~~licensed physician or licensed psychologist~~ health care professional shall every three months certify a patient's need for continued services performed by such facilities.

(4) In order to qualify for participation under this division, every facility specified in this division shall have in effect a plan for utilization review and a plan for peer review and every person specified in this division shall have in effect a plan for peer review. Such plans shall have the purpose of ensuring high quality patient care and efficient utilization of available health facilities and services. Such person or facilities shall also have in effect a program of rehabilitation or a program of rehabilitation and detoxification.

(5) Nothing in this section shall be construed to require reimbursement for benefits which is greater than usual, customary, and reasonable.

(C) The benefits provided by division (A) of this section for mental and emotional disorders shall not be reduced by the cost of benefits provided pursuant to section 3923.282 of the Revised Code for diagnostic and treatment services for biologically based mental illness. This section does not apply to benefits for diagnostic and treatment services for biologically based mental illnesses.

Sec. 3923.51. (A) As used in this section, "official poverty line" means the poverty line as defined by the United States office of management and budget and revised by the secretary of health and human services under 95 Stat. 511, 42 U.S.C.A. 9902, as amended.

(B) Every insurer that is authorized to write sickness and accident insurance in this state may offer group contracts of sickness and accident insurance to any charitable foundation that is certified as exempt from taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and that has the sole purpose of issuing certificates of coverage under these contracts to persons under the age of nineteen who are members of families that have incomes that are no greater than three hundred per cent of the official poverty line.

(C) Contracts offered pursuant to division (B) of this section are not subject to any of the following:

(1) Sections 3923.122, 3923.24, 3923.28, 3923.281, and 3923.29 of the Revised Code;

(2) Any other sickness and accident insurance coverage required under this chapter on August 3, 1989. Any requirement of sickness and accident insurance coverage enacted after that date applies to this section only if the subsequent enactment specifically refers to this section.

(3) Chapter 1751. of the Revised Code.

SECTION 2. That existing sections 1739.05, 1751.01, 1751.02, 3923.28, 3923.30, and 3923.51 of the Revised Code are hereby repealed.

SECTION 3. Section 1751.01 of the Revised Code, as amended by this act, shall apply only to policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state six months after the effective date of this act; section 3923.28 of the Revised Code, as amended by this act, shall apply only to policies of sickness and accident insurance six months after the effective date of this act in accordance with section 3923.01 of the Revised Code; sections 3923.281 and 3923.282 of the Revised Code, as enacted by this act, shall apply only to policies of sickness and accident insurance and plans of health coverage that are established or modified in this state six months after the effective date of this act; and section 3923.30 of the Revised Code, as amended by this act, shall apply only to public employee health plans established or modified in this state six months after the effective date of this act.

SECTION 4. (A) As used in this section, "special hospital" means a hospital that is primarily or exclusively engaged in the care and treatment of one or more of the following:

(1) Patients with a cardiac condition.

(2) Patients with an orthopedic condition.

(3) Patients receiving a surgical procedure.

(4) Patients receiving any other specialized category of services specified by the Director of Health.

(B) Except as provided in division (C) of this section, during the ninety-day period beginning on the effective date of this act, no person, political subdivision, or agency or instrumentality of this state shall establish, develop, or construct a special hospital in a county with a population of more than one hundred forty thousand but less than one

hundred fifty thousand individuals.

(C) The moratorium in division (B) of this section does not affect a project for which all local permits necessary to begin construction were obtained on or prior to the effective date of this act.

(D) The director of health may petition the court of common pleas of the county in which a special hospital is located for an order enjoining any person, political subdivision, or agency or instrumentality of this state from violating division (B) of this section. Irrespective of any other remedy the director may have in law or equity, the court may grant the order on a showing that the respondent named in the petition is violating division (B) of this section.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____