

As Passed by the Senate

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Sub. S. B. No. 116

**Senators Spada, Gardner, Schuring, Hottinger, Fedor, Fingerhut, Miller, R.,
Hagan, Dann, Zurz, Jacobson, Roberts, Prentiss, Austria, Harris, Armbruster,
Goodman, Kearney, Miller, D.**

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A B I L L

To amend sections 1739.05, 1751.01, 1751.02, 3923.28, 1
3923.30, and 3923.51 and to enact sections 2
3923.281 and 3923.282 of the Revised Code to 3
prohibit, subject to certain exceptions, 4
discrimination in group health care policies, 5
contracts, and agreements in the coverage provided 6
for the diagnosis, care, and treatment of 7
biologically based mental illnesses. 8

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1739.05, 1751.01, 1751.02, 3923.28, 9
3923.30, and 3923.51 be amended and sections 3923.281 and 3923.282 10
of the Revised Code be enacted to read as follows: 11

Sec. 1739.05. (A) A multiple employer welfare arrangement 12
that is created pursuant to sections 1739.01 to 1739.22 of the 13
Revised Code and that operates a group self-insurance program may 14
be established only if any of the following applies: 15

(1) The arrangement has and maintains a minimum enrollment of 16
three hundred employees of two or more employers. 17

(2) The arrangement has and maintains a minimum enrollment of 18

three hundred self-employed individuals. 19

(3) The arrangement has and maintains a minimum enrollment of 20
three hundred employees or self-employed individuals in any 21
combination of divisions (A)(1) and (2) of this section. 22

(B) A multiple employer welfare arrangement that is created 23
pursuant to sections 1739.01 to 1739.22 of the Revised Code and 24
that operates a group self-insurance program shall comply with all 25
laws applicable to self-funded programs in this state, including 26
sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 27
to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 28
3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3924.031, 29
3924.032, and 3924.27 of the Revised Code. 30

(C) A multiple employer welfare arrangement created pursuant 31
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 32
enrollments only through agents or solicitors licensed pursuant to 33
Chapter 3905. of the Revised Code to sell or solicit sickness and 34
accident insurance. 35

(D) A multiple employer welfare arrangement created pursuant 36
to sections 1739.01 to 1739.22 of the Revised Code shall provide 37
benefits only to individuals who are members, employees of 38
members, or the dependents of members or employees, or are 39
eligible for continuation of coverage under section 1751.53 or 40
3923.38 of the Revised Code or under Title X of the "Consolidated 41
Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 42
U.S.C.A. 1161, as amended. 43

Sec. 1751.01. As used in this chapter: 44

(A)(1) "Basic health care services" means the following 45
services when medically necessary: 46

~~(1)~~(a) Physician's services, except when such services are 47
supplemental under division (B) of this section; 48

(2) (b) Inpatient hospital services;	49
(3) (c) Outpatient medical services;	50
(4) (d) Emergency health services;	51
(5) (e) Urgent care services;	52
(6) (f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	53 54
(7) (g) <u>Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;</u>	55 56 57
(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.	58 59 60 61
"Basic health care services" does not include experimental procedures.	62 63
A <u>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</u>	64 65 66 67 68 69 70 71 72 73 74 75 76 77 78

of job and family services under Chapter 5111. of the Revised 79
Code, or to the coverage of beneficiaries under any federal health 80
care program regulated by a federal regulatory body, or to the 81
coverage of beneficiaries under any contract covering officers or 82
employees of the state that has been entered into by the 83
department of administrative services. 84

(2) A health insuring corporation may offer coverage for 85
diagnostic and treatment services for biologically based mental 86
illnesses without offering coverage for all other basic health 87
care services. A health insuring corporation may offer coverage 88
for diagnostic and treatment services for biologically based 89
mental illnesses alone or in combination with one or more 90
supplemental health care services. However, a health insuring 91
corporation that offers coverage for any other basic health care 92
service shall offer coverage for diagnostic and treatment services 93
for biologically based mental illnesses in combination with the 94
offer of coverage for all other listed basic health care services. 95

(3) A health insuring corporation that offers coverage for 96
basic health care services is not required to offer coverage for 97
diagnostic and treatment services for biologically based mental 98
illnesses in combination with the offer of coverage for all other 99
listed basic health care services if all of the following apply: 100

(a) The health insuring corporation submits documentation 101
certified by an independent member of the American academy of 102
actuaries to the superintendent of insurance showing that incurred 103
claims for diagnostic and treatment services for biologically 104
based mental illnesses for a period of at least six months 105
independently caused the health insuring corporation's costs for 106
claims and administrative expenses for the coverage of basic 107
health care services to increase by more than one per cent per 108
year. 109

(b) The health insuring corporation submits a signed letter 110

from an independent member of the American academy of actuaries to 111
the superintendent of insurance opining that the increase in costs 112
described in division (A)(3)(a) of this section could reasonably 113
justify an increase of more than one per cent in the annual 114
premiums or rates charged by the health insuring corporation for 115
the coverage of basic health care services. 116

(c) The superintendent of insurance makes the following 117
determinations from the documentation and opinion submitted 118
pursuant to divisions (A)(3)(a) and (b) of this section: 119

(i) Incurred claims for diagnostic and treatment services for 120
biologically based mental illnesses for a period of at least six 121
months independently caused the health insuring corporation's 122
costs for claims and administrative expenses for the coverage of 123
basic health care services to increase by more than one per cent 124
per year. 125

(ii) The increase in costs reasonably justifies an increase 126
of more than one per cent in the annual premiums or rates charged 127
by the health insuring corporation for the coverage of basic 128
health care services. 129

Any determination made pursuant to Chapter 119. of the 130
Revised Code by the superintendent under this division is final. 131

(B) "Supplemental health care services" means any health care 132
services other than basic health care services that a health 133
insuring corporation may offer, alone or in combination with 134
either basic health care services or other supplemental health 135
care services, and includes: 136

(1) Services of facilities for intermediate or long-term 137
care, or both; 138

(2) Dental care services; 139

(3) Vision care and optometric services including lenses and 140

frames;	141
(4) Podiatric care or foot care services;	142
(5) Mental health services including psychological services, <u>excluding diagnostic and treatment services for biologically based</u> <u>mental illnesses;</u>	143 144 145
(6) Short-term outpatient evaluative and crisis-intervention mental health services;	146 147
(7) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;	148 149
(8) Home health services;	150
(9) Prescription drug services;	151
(10) Nursing services;	152
(11) Services of a dietitian licensed under Chapter 4759. of the Revised Code;	153 154
(12) Physical therapy services;	155
(13) Chiropractic services;	156
(14) Any other category of services approved by the superintendent of insurance.	157 158
(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.	159 160 161 162 163
(D) <u>"Biologically based mental illnesses" means</u> <u>schizophrenia, schizoaffective disorder, major depressive</u> <u>disorder, bipolar disorder, paranoia and other psychotic</u> <u>disorders, obsessive-compulsive disorder, and panic disorder, as</u> <u>these terms are defined in the most recent edition of the</u> <u>diagnostic and statistical manual of mental disorders published by</u>	164 165 166 167 168 169

<u>the American psychiatric association.</u>	170
<u>(E)</u> "Closed panel plan" means a health care plan that requires enrollees to use participating providers.	171 172
(E) <u>(F)</u> "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.	173 174 175
(F) <u>(G)</u> "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.	176 177 178
(G) <u>(H)</u> "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.	179 180 181
(H) <u>(I)</u> "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.	182 183 184 185 186 187 188
(I) <u>(J)</u> "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.	189 190 191
(J) <u>(K)</u> "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.	192 193 194 195
(K) <u>(L)</u> "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	196 197 198 199

nursing services. 200

~~(I)~~(M) "Health care services" means basic, supplemental, and 201
specialty health care services. 202

~~(M)~~(N) "Health delivery network" means any group of providers 203
or health care facilities, or both, or any representative thereof, 204
that have entered into an agreement to offer health care services 205
in a panel rather than on an individual basis. 206

~~(N)~~(O) "Health insuring corporation" means a corporation, as 207
defined in division ~~(G)~~(H) of this section, that, pursuant to a 208
policy, contract, certificate, or agreement, pays for, reimburses, 209
or provides, delivers, arranges for, or otherwise makes available, 210
basic health care services, supplemental health care services, or 211
specialty health care services, or a combination of basic health 212
care services and either supplemental health care services or 213
specialty health care services, through either an open panel plan 214
or a closed panel plan. 215

"Health insuring corporation" does not include a limited 216
liability company formed pursuant to Chapter 1705. of the Revised 217
Code, an insurer licensed under Title XXXIX of the Revised Code if 218
that insurer offers only open panel plans under which all 219
providers and health care facilities participating receive their 220
compensation directly from the insurer, a corporation formed by or 221
on behalf of a political subdivision or a department, office, or 222
institution of the state, or a public entity formed by or on 223
behalf of a board of county commissioners, a county board of 224
mental retardation and developmental disabilities, an alcohol and 225
drug addiction services board, a board of alcohol, drug addiction, 226
and mental health services, or a community mental health board, as 227
those terms are used in Chapters 340. and 5126. of the Revised 228
Code. Except as provided by division (D) of section 1751.02 of the 229
Revised Code, or as otherwise provided by law, no board, 230
commission, agency, or other entity under the control of a 231

political subdivision may accept insurance risk in providing for 232
health care services. However, nothing in this division shall be 233
construed as prohibiting such entities from purchasing the 234
services of a health insuring corporation or a third-party 235
administrator licensed under Chapter 3959. of the Revised Code. 236

~~(O)~~(P) "Intermediary organization" means a health delivery 237
network or other entity that contracts with licensed health 238
insuring corporations or self-insured employers, or both, to 239
provide health care services, and that enters into contractual 240
arrangements with other entities for the provision of health care 241
services for the purpose of fulfilling the terms of its contracts 242
with the health insuring corporations and self-insured employers. 243

~~(P)~~(O) "Intermediate care" means residential care above the 244
level of room and board for patients who require personal 245
assistance and health-related services, but who do not require 246
skilled nursing care. 247

~~(Q)~~(R) "Medical record" means the personal information that 248
relates to an individual's physical or mental condition, medical 249
history, or medical treatment. 250

~~(R)~~(S)(1) "Open panel plan" means a health care plan that 251
provides incentives for enrollees to use participating providers 252
and that also allows enrollees to use providers that are not 253
participating providers. 254

(2) No health insuring corporation may offer an open panel 255
plan, unless the health insuring corporation is also licensed as 256
an insurer under Title XXXIX of the Revised Code, the health 257
insuring corporation, on June 4, 1997, holds a certificate of 258
authority or license to operate under Chapter 1736. or 1740. of 259
the Revised Code, or an insurer licensed under Title XXXIX of the 260
Revised Code is responsible for the out-of-network risk as 261
evidenced by both an evidence of coverage filing under section 262

1751.11 of the Revised Code and a policy and certificate filing 263
under section 3923.02 of the Revised Code. 264

~~(S)~~(T) "Panel" means a group of providers or health care 265
facilities that have joined together to deliver health care 266
services through a contractual arrangement with a health insuring 267
corporation, employer group, or other payor. 268

~~(T)~~(U) "Person" has the same meaning as in section 1.59 of 269
the Revised Code, and, unless the context otherwise requires, 270
includes any insurance company holding a certificate of authority 271
under Title XXXIX of the Revised Code, any subsidiary and 272
affiliate of an insurance company, and any government agency. 273

~~(U)~~(V) "Premium rate" means any set fee regularly paid by a 274
subscriber to a health insuring corporation. A "premium rate" does 275
not include a one-time membership fee, an annual administrative 276
fee, or a nominal access fee, paid to a managed health care system 277
under which the recipient of health care services remains solely 278
responsible for any charges accessed for those services by the 279
provider or health care facility. 280

~~(V)~~(W) "Primary care provider" means a provider that is 281
designated by a health insuring corporation to supervise, 282
coordinate, or provide initial care or continuing care to an 283
enrollee, and that may be required by the health insuring 284
corporation to initiate a referral for specialty care and to 285
maintain supervision of the health care services rendered to the 286
enrollee. 287

~~(W)~~(X) "Provider" means any natural person or partnership of 288
natural persons who are licensed, certified, accredited, or 289
otherwise authorized in this state to furnish health care 290
services, or any professional association organized under Chapter 291
1785. of the Revised Code, provided that nothing in this chapter 292
or other provisions of law shall be construed to preclude a health 293

insuring corporation, health care practitioner, or organized 294
health care group associated with a health insuring corporation 295
from employing certified nurse practitioners, certified nurse 296
anesthetists, clinical nurse specialists, certified nurse 297
midwives, dietitians, physician assistants, dental assistants, 298
dental hygienists, optometric technicians, or other allied health 299
personnel who are licensed, certified, accredited, or otherwise 300
authorized in this state to furnish health care services. 301

~~(X)~~(Y) "Provider sponsored organization" means a corporation, 302
as defined in division ~~(G)~~(H) of this section, that is at least 303
eighty per cent owned or controlled by one or more hospitals, as 304
defined in section 3727.01 of the Revised Code, or one or more 305
physicians licensed to practice medicine or surgery or osteopathic 306
medicine and surgery under Chapter 4731. of the Revised Code, or 307
any combination of such physicians and hospitals. Such control is 308
presumed to exist if at least eighty per cent of the voting rights 309
or governance rights of a provider sponsored organization are 310
directly or indirectly owned, controlled, or otherwise held by any 311
combination of the physicians and hospitals described in this 312
division. 313

~~(Y)~~(Z) "Solicitation document" means the written materials 314
provided to prospective subscribers or enrollees, or both, and 315
used for advertising and marketing to induce enrollment in the 316
health care plans of a health insuring corporation. 317

~~(Z)~~(AA) "Subscriber" means a person who is responsible for 318
making payments to a health insuring corporation for participation 319
in a health care plan, or an enrollee whose employment or other 320
status is the basis of eligibility for enrollment in a health 321
insuring corporation. 322

~~(AA)~~(BB) "Urgent care services" means those health care 323
services that are appropriately provided for an unforeseen 324
condition of a kind that usually requires medical attention 325

without delay but that does not pose a threat to the life, limb, 326
or permanent health of the injured or ill person, and may include 327
such health care services provided out of the health insuring 328
corporation's approved service area pursuant to indemnity payments 329
or service agreements. 330

Sec. 1751.02. (A) Notwithstanding any law in this state to 331
the contrary, any corporation, as defined in section 1751.01 of 332
the Revised Code, may apply to the superintendent of insurance for 333
a certificate of authority to establish and operate a health 334
insuring corporation. If the corporation applying for a 335
certificate of authority is a foreign corporation domiciled in a 336
state without laws similar to those of this chapter, the 337
corporation must form a domestic corporation to apply for, obtain, 338
and maintain a certificate of authority under this chapter. 339

(B) No person shall establish, operate, or perform the 340
services of a health insuring corporation in this state without 341
obtaining a certificate of authority under this chapter. 342

(C) Except as provided by division (D) of this section, no 343
political subdivision or department, office, or institution of 344
this state, or corporation formed by or on behalf of any political 345
subdivision or department, office, or institution of this state, 346
shall establish, operate, or perform the services of a health 347
insuring corporation. Nothing in this section shall be construed 348
to preclude a board of county commissioners, a county board of 349
mental retardation and developmental disabilities, an alcohol and 350
drug addiction services board, a board of alcohol, drug addiction, 351
and mental health services, or a community mental health board, or 352
a public entity formed by or on behalf of any of these boards, 353
from using managed care techniques in carrying out the board's or 354
public entity's duties pursuant to the requirements of Chapters 355
307., 329., 340., and 5126. of the Revised Code. However, no such 356

board or public entity may operate so as to compete in the private 357
sector with health insuring corporations holding certificates of 358
authority under this chapter. 359

(D) A corporation formed by or on behalf of a publicly owned, 360
operated, or funded hospital or health care facility may apply to 361
the superintendent for a certificate of authority under division 362
(A) of this section to establish and operate a health insuring 363
corporation. 364

(E) A health insuring corporation shall operate in this state 365
in compliance with this chapter and Chapter 1753. of the Revised 366
Code, and with sections 3702.51 to 3702.62 of the Revised Code, 367
and shall operate in conformity with its filings with the 368
superintendent under this chapter, including filings made pursuant 369
to sections 1751.03, 1751.11, 1751.12, and 1751.31 of the Revised 370
Code. 371

(F) An insurer licensed under Title XXXIX of the Revised Code 372
need not obtain a certificate of authority as a health insuring 373
corporation to offer an open panel plan as long as the providers 374
and health care facilities participating in the open panel plan 375
receive their compensation directly from the insurer. If the 376
providers and health care facilities participating in the open 377
panel plan receive their compensation from any person other than 378
the insurer, or if the insurer offers a closed panel plan, the 379
insurer must obtain a certificate of authority as a health 380
insuring corporation. 381

(G) An intermediary organization need not obtain a 382
certificate of authority as a health insuring corporation, 383
regardless of the method of reimbursement to the intermediary 384
organization, as long as a health insuring corporation or a 385
self-insured employer maintains the ultimate responsibility to 386
assure delivery of all health care services required by the 387

contract between the health insuring corporation and the 388
subscriber and the laws of this state or between the self-insured 389
employer and its employees. 390

Nothing in this section shall be construed to require any 391
health care facility, provider, health delivery network, or 392
intermediary organization that contracts with a health insuring 393
corporation or self-insured employer, regardless of the method of 394
reimbursement to the health care facility, provider, health 395
delivery network, or intermediary organization, to obtain a 396
certificate of authority as a health insuring corporation under 397
this chapter, unless otherwise provided, in the case of contracts 398
with a self-insured employer, by operation of the "Employee 399
Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 400
1001, as amended. 401

(H) Any health delivery network doing business in this state, 402
including any health delivery network that is functioning as an 403
intermediary organization doing business in this state, that is 404
not required to obtain a certificate of authority under this 405
chapter shall certify to the superintendent annually, not later 406
than the first day of July, and shall provide a statement signed 407
by the highest ranking official which includes the following 408
information: 409

(1) The health delivery network's full name and the address 410
of its principal place of business; 411

(2) A statement that the health delivery network is not 412
required to obtain a certificate of authority under this chapter 413
to conduct its business. 414

(I) The superintendent shall not issue a certificate of 415
authority to a health insuring corporation that is a provider 416
sponsored organization unless all health care plans to be offered 417
by the health insuring corporation provide basic health care 418

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 450
evaluations, that are at least equal to five hundred fifty dollars 451
in any calendar year or twelve-month period. The services shall be 452
legally performed by or under the clinical supervision of a 453
~~licensed physician or licensed~~ authorized under Chapter 4731. of 454
the Revised Code to practice medicine and surgery or osteopathic 455
medicine and surgery; a psychologist licensed under Chapter 4732. 456
of the Revised Code; a professional clinical counselor, 457
professional counselor, or independent social worker licensed 458
under Chapter 4757. of the Revised Code; or a clinical nurse 459
specialist licensed under Chapter 4723. of the Revised Code whose 460
nursing specialty is mental health, whether performed in an 461
office, in a hospital, or in a community mental health facility so 462
long as the hospital or community mental health facility is 463
approved by the joint commission on accreditation of healthcare 464
organizations, the council on accreditation for children and 465
family services, the rehabilitation accreditation commission, or, 466
until two years after ~~the effective date of this amendment~~ June 6, 467
2001, certified by the department of mental health as being in 468
compliance with standards established under division (H) of 469
section 5119.01 of the Revised Code. 470

(B) Outpatient benefits offered under division (A) of this 471
section shall be subject to reasonable contract limitations and 472
may be subject to reasonable deductibles and co-insurance costs. 473
Persons entitled to such benefit under more than one service or 474
insurance contract may be limited to a single 475
five-hundred-fifty-dollar outpatient benefit for services under 476
all contracts. 477

(C) In order to qualify for participation under division (A) 478
of this section, every facility specified in such division shall 479
have in effect a plan for utilization review and a plan for peer 480
review and every person specified in such division shall have in 481

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: 513

(1) "Biologically based mental illness" means schizophrenia, 514
schizoaffective disorder, major depressive disorder, bipolar 515
disorder, paranoia and other psychotic disorders, 516
obsessive-compulsive disorder, and panic disorder, as these terms 517
are defined in the most recent edition of the diagnostic and 518
statistical manual of mental disorders published by the American 519
psychiatric association. 520

(2) "Policy of sickness and accident insurance" has the same 521
meaning as in section 3923.01 of the Revised Code, but excludes 522
any hospital indemnity, medicare supplement, long-term care, 523
disability income, one-time-limited-duration policy of not longer 524
than six months, supplemental benefit, or other policy that 525
provides coverage for specific diseases or accidents only; any 526
policy or certificate of sickness and accident insurance that is 527
underwritten by an insurer on an individual basis; any policy that 528
provides coverage for workers' compensation claims compensable 529
pursuant to Chapters 4121. and 4123. of the Revised Code; and any 530
policy that provides coverage to beneficiaries enrolled in Title 531
XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 532
301, as amended, known as the medical assistance program or 533
medicaid, as provided by the Ohio department of job and family 534
services under Chapter 5111. of the Revised Code. 535

(B) Notwithstanding section 3901.71 of the Revised Code, and 536
subject to division (E) of this section, every group policy of 537
sickness and accident insurance shall provide benefits for the 538
diagnosis and treatment of biologically based mental illnesses on 539
the same terms and conditions as, and shall provide benefits no 540
less extensive than, those provided under the policy of sickness 541
and accident insurance for the treatment and diagnosis of all 542
other physical diseases and disorders, if both of the following 543

apply: 544

(1) The biologically based mental illness is clinically 545
diagnosed by a physician authorized under Chapter 4731. of the 546
Revised Code to practice medicine and surgery or osteopathic 547
medicine and surgery; a psychologist licensed under Chapter 4732. 548
of the Revised Code; a professional clinical counselor, 549
professional counselor, or independent social worker licensed 550
under Chapter 4757. of the Revised Code; or a clinical nurse 551
specialist licensed under Chapter 4723. of the Revised Code whose 552
nursing specialty is mental health. 553

(2) The prescribed treatment is not experimental or 554
investigational, having proven its clinical effectiveness in 555
accordance with generally accepted medical standards. 556

(C) Division (B) of this section applies to all coverages and 557
terms and conditions of the policy of sickness and accident 558
insurance, including, but not limited to, coverage of inpatient 559
hospital services, outpatient services, and medication; maximum 560
lifetime benefits; copayments; and individual and family 561
deductibles. 562

(D) Nothing in this section shall be construed as prohibiting 563
a sickness and accident insurance company from taking any of the 564
following actions: 565

(1) Negotiating separately with mental health care providers 566
with regard to reimbursement rates and the delivery of health care 567
services; 568

(2) Offering policies that provide benefits solely for the 569
diagnosis and treatment of biologically based mental illnesses; 570

(3) Managing the provision of benefits for the diagnosis or 571
treatment of biologically based mental illnesses through the use 572
of pre-admission screening, by requiring beneficiaries to obtain 573

authorization prior to treatment, or through the use of any other 574
mechanism designed to limit coverage to that treatment determined 575
to be necessary; 576

(4) Enforcing the terms and conditions of a policy of 577
sickness and accident insurance. 578

(E) An insurer that offers a group policy of sickness and 579
accident insurance is not required to provide benefits for the 580
diagnosis and treatment of biologically based mental illnesses 581
pursuant to division (B) of this section if all of the following 582
apply: 583

(1) The insurer submits documentation certified by an 584
independent member of the American academy of actuaries to the 585
superintendent of insurance showing that incurred claims for 586
diagnostic and treatment services for biologically based mental 587
illnesses for a period of at least six months independently caused 588
the insurer's costs for claims and administrative expenses for the 589
coverage of all other physical diseases and disorders to increase 590
by more than one per cent per year. 591

(2) The insurer submits a signed letter from an independent 592
member of the American academy of actuaries to the superintendent 593
of insurance opining that the increase described in division 594
(E)(1) of this section could reasonably justify an increase of 595
more than one per cent in the annual premiums or rates charged by 596
the insurer for the coverage of all other physical diseases and 597
disorders. 598

(3) The superintendent of insurance makes the following 599
determinations from the documentation and opinion submitted 600
pursuant to divisions (E)(1) and (2) of this section: 601

(a) Incurred claims for diagnostic and treatment services for 602
biologically based mental illnesses for a period of at least six 603
months independently caused the insurer's costs for claims and 604

administrative expenses for the coverage of all other physical 605
diseases and disorders to increase by more than one per cent per 606
year. 607

(b) The increase in costs reasonably justifies an increase of 608
more than one per cent in the annual premiums or rates charged by 609
the insurer for the coverage of all other physical diseases and 610
disorders. 611

Any determination made pursuant to Chapter 119. of the 612
Revised Code by the superintendent under this division is final. 613

Sec. 3923.282. (A) As used in this section: 614

(1) "Biologically based mental illness" means schizophrenia, 615
schizoaffective disorder, major depressive disorder, bipolar 616
disorder, paranoia and other psychotic disorders, 617
obsessive-compulsive disorder, and panic disorder, as these terms 618
are defined in the most recent edition of the diagnostic and 619
statistical manual of mental disorders published by the American 620
psychiatric association. 621

(2) "Plan of health coverage" includes any private or public 622
employer group self-insurance plan that provides payment for 623
health care benefits for other than specific diseases or accidents 624
only, which benefits are not provided by contract with a sickness 625
and accident insurer or health insuring corporation. 626

(B) Notwithstanding section 3901.71 of the Revised Code, and 627
subject to division (F) of this section, each plan of health 628
coverage shall provide benefits for the diagnosis and treatment of 629
biologically based mental illnesses on the same terms and 630
conditions as, and shall provide benefits no less extensive than, 631
those provided under the plan of health coverage for the treatment 632
and diagnosis of all other physical diseases and disorders, if 633
both of the following apply: 634

(1) The biologically based mental illness is clinically 635
diagnosed by a physician authorized under Chapter 4731. of the 636
Revised Code to practice medicine and surgery or osteopathic 637
medicine and surgery; a psychologist licensed under Chapter 4732. 638
of the Revised Code; a professional clinical counselor, 639
professional counselor, or independent social worker licensed 640
under Chapter 4757. of the Revised Code; or a clinical nurse 641
specialist licensed under Chapter 4723. of the Revised Code whose 642
nursing specialty is mental health. 643

(2) The prescribed treatment is not experimental or 644
investigational, having proven its clinical effectiveness in 645
accordance with generally accepted medical standards. 646

(C) Division (B) of this section applies to all coverages and 647
terms and conditions of the plan of health coverage, including, 648
but not limited to, coverage of inpatient hospital services, 649
outpatient services, and medication; maximum lifetime benefits; 650
copayments; and individual and family deductibles. 651

(D) This section does not apply to a plan of health coverage 652
if federal law supersedes, preempts, prohibits, or otherwise 653
precludes its application to such plans. This section does not 654
apply to long-term care, hospital indemnity, disability income, or 655
medicare supplement plans of health coverage, or to any other 656
supplemental benefit plans of health coverage. 657

(E) Nothing in this section shall be construed as prohibiting 658
an employer from taking any of the following actions in connection 659
with a plan of health coverage: 660

(1) Negotiating separately with mental health care providers 661
with regard to reimbursement rates and the delivery of health care 662
services; 663

(2) Managing the provision of benefits for the diagnosis or 664
treatment of biologically based mental illnesses through the use 665

of pre-admission screening, by requiring beneficiaries to obtain 666
authorization prior to treatment, or through the use of any other 667
mechanism designed to limit coverage to that treatment determined 668
to be necessary; 669

(3) Enforcing the terms and conditions of a plan of health 670
coverage. 671

(F) An employer that offers a plan of health coverage is not 672
required to provide benefits for the diagnosis and treatment of 673
biologically based mental illnesses in combination with benefits 674
for the treatment and diagnosis of all other physical diseases and 675
disorders as described in division (B) of this section if both of 676
the following apply: 677

(1) The employer submits documentation certified by an 678
independent member of the American academy of actuaries to the 679
superintendent of insurance showing that incurred claims for 680
diagnostic and treatment services for biologically based mental 681
illnesses for a period of at least six months independently caused 682
the employer's costs for claims and administrative expenses for 683
the coverage of all other physical diseases and disorders to 684
increase by more than one per cent per year. 685

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(2) The superintendent of insurance determines from the 687
documentation and opinion submitted pursuant to division (F) of 688
this section, that incurred claims for diagnostic and treatment 689
services for biologically based mental illnesses for a period of 690
at least six months independently caused the employer's costs for 691
claims and administrative expenses for the coverage of all other 692
physical diseases and disorders to increase by more than one per 693
cent per year. 694

Any determination made pursuant to Chapter 119. of the 695
Revised Code by the superintendent under this division is final. 696

Sec. 3923.30. Every person, the state and any of its 697
instrumentalities, any county, township, school district, or other 698
political subdivisions and any of its instrumentalities, and any 699
municipal corporation and any of its instrumentalities, which 700
provides payment for health care benefits for any of its employees 701
resident in this state, which benefits are not provided by 702
contract with an insurer qualified to provide sickness and 703
accident insurance, or a health insuring corporation, shall 704
include the following benefits in its plan of health care benefits 705
commencing on or after January 1, 1979: 706

(A) If such plan of health care benefits provides payment for 707
the treatment of mental or nervous disorders, then such plan shall 708
provide benefits for services on an outpatient basis for each 709
eligible employee and dependent for mental or emotional disorders, 710
or for evaluations, that are at least equal to the following: 711

(1) Payments not less than five hundred fifty dollars in a 712
twelve-month period, for services legally performed by or under 713
the clinical supervision of a ~~licensed~~ physician ~~or a licensed~~ 714
authorized under Chapter 4731. of the Revised Code to practice 715
medicine and surgery or osteopathic medicine and surgery; a 716
psychologist licensed under Chapter 4732. of the Revised Code; a 717
professional clinical counselor, professional counselor, or 718
independent social worker licensed under Chapter 4757. of the 719
Revised Code; or a clinical nurse specialist licensed under 720
Chapter 4723. of the Revised Code whose nursing specialty is 721
mental health, whether performed in an office, in a hospital, or 722
in a community mental health facility so long as the hospital or 723
community mental health facility is approved by the joint 724
commission on accreditation of healthcare organizations, the 725
council on accreditation for children and family services, the 726
rehabilitation accreditation commission, or, until two years after 727

~~the effective date of this amendment~~ June 6, 2001, certified by 728
the department of mental health as being in compliance with 729
standards established under division (H) of section 5119.01 of the 730
Revised Code; 731

(2) Such benefit shall be subject to reasonable limitations, 732
and may be subject to reasonable deductibles and co-insurance 733
costs. 734

(3) In order to qualify for participation under this 735
division, every facility specified in this division shall have in 736
effect a plan for utilization review and a plan for peer review 737
and every person specified in this division shall have in effect a 738
plan for peer review. Such plans shall have the purpose of 739
ensuring high quality patient care and effective and efficient 740
utilization of available health facilities and services. 741

(4) Such payment for benefits shall not be greater than 742
usual, customary, and reasonable. 743

(5)(a) Services performed by or under the clinical 744
supervision of a ~~licensed physician or licensed psychologist~~ 745
health care professional identified in division (A)(1) of this 746
section, in order to be reimbursable under the coverage required 747
in division (A) of this section, shall meet both of the following 748
requirements: 749

(i) The services shall be performed in accordance with a 750
treatment plan that describes the expected duration, frequency, 751
and type of services to be performed; 752

(ii) The plan shall be reviewed and approved by ~~a licensed~~ 753
~~physician or licensed psychologist~~ the health care professional 754
every three months. 755

(b) Payment of benefits for services reimbursable under 756
division (A)(5)(a) of the section shall not be restricted to 757
services described in the treatment plan or conditioned upon 758

standards of a licensed physician or licensed psychologist, which 759
at least equal the requirements of division (A)(5)(a) of this 760
section. 761

(B) Payment for benefits for alcoholism treatment for 762
outpatient, inpatient, and intermediate primary care for each 763
eligible employee and dependent that are at least equal to the 764
following: 765

(1) Payments not less than five hundred fifty dollars in a 766
twelve-month period for services legally performed by or under the 767
clinical supervision of a ~~licensed physician or licensed~~ 768
~~psychologist~~ health care professional identified in division 769
(A)(1) of this section, whether performed in an office, or in a 770
hospital or a community mental health facility or alcoholism 771
treatment facility so long as the hospital, community mental 772
health facility, or alcoholism treatment facility is approved by 773
the joint commission on accreditation of hospitals or certified by 774
the department of health; 775

(2) The benefits provided under this division shall be 776
subject to reasonable limitations and may be subject to reasonable 777
deductibles and co-insurance costs. 778

(3) A ~~licensed physician or licensed psychologist~~ health care 779
professional shall every three months certify a patient's need for 780
continued services performed by such facilities. 781

(4) In order to qualify for participation under this 782
division, every facility specified in this division shall have in 783
effect a plan for utilization review and a plan for peer review 784
and every person specified in this division shall have in effect a 785
plan for peer review. Such plans shall have the purpose of 786
ensuring high quality patient care and efficient utilization of 787
available health facilities and services. Such person or 788
facilities shall also have in effect a program of rehabilitation 789

or a program of rehabilitation and detoxification.

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

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(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.

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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.

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(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.

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

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

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(2) Any other sickness and accident insurance coverage 820
required under this chapter on August 3, 1989. Any requirement of 821
sickness and accident insurance coverage enacted after that date 822
applies to this section only if the subsequent enactment 823
specifically refers to this section. 824

(3) Chapter 1751. of the Revised Code. 825

Section 2. That existing sections 1739.05, 1751.01, 1751.02, 826
3923.28, 3923.30, and 3923.51 of the Revised Code are hereby 827
repealed. 828

Section 3. Section 1751.01 of the Revised Code, as amended by 829
this act, shall apply only to policies, contracts, and agreements 830
that are delivered, issued for delivery, or renewed in this state 831
six months after the effective date of this act; section 3923.28 832
of the Revised Code, as amended by this act, shall apply only to 833
policies of sickness and accident insurance six months after the 834
effective date of this act in accordance with section 3923.01 of 835
the Revised Code; sections 3923.281 and 3923.282 of the Revised 836
Code, as enacted by this act, shall apply only to policies of 837
sickness and accident insurance and plans of health coverage that 838
are established or modified in this state six months after the 839
effective date of this act; and section 3923.30 of the Revised 840
Code, as amended by this act, shall apply only to public employee 841
health plans established or modified in this state six months 842
after the effective date of this act. 843