

As Introduced

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Representatives Celeste, Peterson

**Cosponsors: Representatives Beatty, Healy, Brady, Ujvagi, Fende, Skindell,
Letson, Hagan, R., Foley, Williams, S., Yuko, Bolon, Otterman, Driehaus,
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A B I L L

To amend sections 1739.05, 1751.01, 3923.281, 1
3923.282, and 3923.51 and to repeal sections 2
3923.28, 3923.29, and 3923.30 of the Revised Code 3
to prohibit discrimination in health care 4
policies, contracts, and agreements in the 5
coverage provided for the diagnosis and treatment 6
of mental illnesses and substance abuse or 7
addiction conditions. 8

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

Section 1. That sections 1739.05, 1751.01, 3923.281, 9
3923.282, and 3923.51 of the Revised Code be amended to read as 10
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

(a) Physician's services, except when such services are 47

supplemental under division (B) of this section;	48
(b) Inpatient hospital services;	49
(c) Outpatient medical services;	50
(d) Emergency health services;	51
(e) Urgent care services;	52
(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	53 54
(g) Diagnostic and treatment services, other than prescription drug services , for <u>biologically based mental</u> <u>illnesses and substance abuse or addiction conditions</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
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 <u>and</u> <u>substance abuse or addiction conditions</u> , 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	64 65 66 67 68 69 70 71 72 73 74 75 76 77

U.S.C.A. 301, as amended, known as the medical assistance program 78
or medicaid, provided by the department of job and family services 79
under Chapter 5111. of the Revised Code, or to the coverage of 80
beneficiaries under any federal health care program regulated by a 81
federal regulatory body, or to the coverage of beneficiaries under 82
any contract covering officers or employees of the state that has 83
been entered into by the 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 and substance abuse or addiction conditions without 87
offering coverage for all other basic health care services. A 88
health insuring corporation may offer coverage for diagnostic and 89
treatment services for ~~biologically based~~ mental illnesses and 90
substance abuse or addiction conditions alone or in combination 91
with one or more supplemental health care services. However, a 92
health insuring corporation that offers coverage for any other 93
basic health care service shall offer coverage for diagnostic and 94
treatment services for ~~biologically based~~ mental illnesses and 95
substance abuse or addiction conditions in combination with the 96
offer of coverage for all other listed basic health care services. 97

(3) A health insuring corporation that offers coverage for 98
basic health care services is not required to offer coverage for 99
diagnostic and treatment services for ~~biologically based~~ mental 100
illnesses and substance abuse or addiction conditions in 101
combination with the offer of coverage for all other listed basic 102
health care services if all of the following apply: 103

(a) The health insuring corporation submits documentation 104
certified by an independent member of the American academy of 105
actuaries to the superintendent of insurance showing that incurred 106
claims for diagnostic and treatment services for ~~biologically~~ 107
~~based~~ mental illnesses and substance abuse or addiction conditions 108
for a period of at least six months independently caused the 109

health insuring corporation's costs for claims and administrative 110
expenses for the coverage of basic health care services to 111
increase by more than one per cent per year. 112

(b) The health insuring corporation submits a signed letter 113
from an independent member of the American academy of actuaries to 114
the superintendent of insurance opining that the increase in costs 115
described in division (A)(3)(a) of this section could reasonably 116
justify an increase of more than one per cent in the annual 117
premiums or rates charged by the health insuring corporation for 118
the coverage of basic health care services. 119

(c) The superintendent of insurance makes the following 120
determinations from the documentation and opinion submitted 121
pursuant to divisions (A)(3)(a) and (b) of this section: 122

(i) Incurred claims for diagnostic and treatment services for 123
~~biologically based~~ mental illnesses and substance abuse or 124
addiction conditions for a period of at least six months 125
independently caused the health insuring corporation's costs for 126
claims and administrative expenses for the coverage of basic 127
health care services to increase by more than one per cent per 128
year. 129

(ii) The increase in costs reasonably justifies an increase 130
of more than one per cent in the annual premiums or rates charged 131
by the health insuring corporation for the coverage of basic 132
health care services. 133

Any determination made by the superintendent under this 134
division is subject to Chapter 119. of the Revised Code. 135

(B)(1) "Supplemental health care services" means any health 136
care services other than basic health care services that a health 137
insuring corporation may offer, alone or in combination with 138
either basic health care services or other supplemental health 139
care services, and includes: 140

(a) Services of facilities for intermediate or long-term care, or both;	141 142
(b) Dental care services;	143
(c) Vision care and optometric services including lenses and frames;	144 145
(d) Podiatric care or foot care services;	146
(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;	147 148
(f) Short-term outpatient evaluative and crisis-intervention mental health services;	149 150
(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;	151 152
(h) <u>(f)</u> Home health services;	153
(i) <u>(g)</u> Prescription drug services;	154
(j) <u>(h)</u> Nursing services;	155
(k) <u>(i)</u> Services of a dietitian licensed under Chapter 4759. of the Revised Code;	156 157
(l) <u>(j)</u> Physical therapy services;	158
(m) <u>(k)</u> Chiropractic services;	159
(n) <u>(l)</u> Any other category of services approved by the superintendent of insurance.	160 161
(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.	162 163 164 165 166
(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this	167 168

section, when provided by a health insuring corporation on an 169
outpatient-only basis and not in combination with other 170
supplemental health care services. 171

(D) ~~"Biologically based mental illnesses" means~~ 172
~~schizophrenia, schizoaffective disorder, major depressive~~ 173
~~disorder, bipolar disorder, paranoia and other psychotic~~ 174
~~disorders, obsessive compulsive disorder, and panic disorder, as~~ 175
~~these terms are defined in~~ "Mental illness" means any condition or 176
disorder involving mental illness as defined by the most recent 177
edition of the diagnostic and statistical manual of mental 178
disorders published by the American psychiatric association or as 179
defined by any diagnostic category listed in the mental disorder 180
section of the most recent edition of the international 181
classification of diseases. 182

(E) "Substance abuse or addiction condition" means any 183
alcohol or drug related disorder as defined by the most recent 184
edition of the diagnostic and statistical manual of mental 185
disorders published by the American psychiatric association or as 186
defined by a diagnostic category listed in the most recent edition 187
of the international classification of diseases. 188

(F) "Closed panel plan" means a health care plan that 189
requires enrollees to use participating providers. 190

~~(F)~~(G) "Compensation" means remuneration for the provision of 191
health care services, determined on other than a fee-for-service 192
or discounted-fee-for-service basis. 193

~~(G)~~(H) "Contractual periodic prepayment" means the formula 194
for determining the premium rate for all subscribers of a health 195
insuring corporation. 196

~~(H)~~(I) "Corporation" means a corporation formed under Chapter 197
1701. or 1702. of the Revised Code or the similar laws of another 198
state. 199

~~(I)~~(J) "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.

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

~~(K)~~(L) "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.

~~(L)~~(M) "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.

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

~~(N)~~(O) "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.

~~(O)~~(P) "Health insuring corporation" means a corporation, as defined in division ~~(H)~~(I) 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 231
specialty health care services, through either an open panel plan 232
or a closed panel plan. 233

"Health insuring corporation" does not include a limited 234
liability company formed pursuant to Chapter 1705. of the Revised 235
Code, an insurer licensed under Title XXXIX of the Revised Code if 236
that insurer offers only open panel plans under which all 237
providers and health care facilities participating receive their 238
compensation directly from the insurer, a corporation formed by or 239
on behalf of a political subdivision or a department, office, or 240
institution of the state, or a public entity formed by or on 241
behalf of a board of county commissioners, a county board of 242
mental retardation and developmental disabilities, an alcohol and 243
drug addiction services board, a board of alcohol, drug addiction, 244
and mental health services, or a community mental health board, as 245
those terms are used in Chapters 340. and 5126. of the Revised 246
Code. Except as provided by division (D) of section 1751.02 of the 247
Revised Code, or as otherwise provided by law, no board, 248
commission, agency, or other entity under the control of a 249
political subdivision may accept insurance risk in providing for 250
health care services. However, nothing in this division shall be 251
construed as prohibiting such entities from purchasing the 252
services of a health insuring corporation or a third-party 253
administrator licensed under Chapter 3959. of the Revised Code. 254

~~(P)~~(Q) "Intermediary organization" means a health delivery 255
network or other entity that contracts with licensed health 256
insuring corporations or self-insured employers, or both, to 257
provide health care services, and that enters into contractual 258
arrangements with other entities for the provision of health care 259
services for the purpose of fulfilling the terms of its contracts 260
with the health insuring corporations and self-insured employers. 261

~~(Q)~~(R) "Intermediate care" means residential care above the 262

level of room and board for patients who require personal 263
assistance and health-related services, but who do not require 264
skilled nursing care. 265

~~(R)~~(S) "Medical record" means the personal information that 266
relates to an individual's physical or mental condition, medical 267
history, or medical treatment. 268

~~(S)~~(T)(1) "Open panel plan" means a health care plan that 269
provides incentives for enrollees to use participating providers 270
and that also allows enrollees to use providers that are not 271
participating providers. 272

(2) No health insuring corporation may offer an open panel 273
plan, unless the health insuring corporation is also licensed as 274
an insurer under Title XXXIX of the Revised Code, the health 275
insuring corporation, on June 4, 1997, holds a certificate of 276
authority or license to operate under Chapter 1736. or 1740. of 277
the Revised Code, or an insurer licensed under Title XXXIX of the 278
Revised Code is responsible for the out-of-network risk as 279
evidenced by both an evidence of coverage filing under section 280
1751.11 of the Revised Code and a policy and certificate filing 281
under section 3923.02 of the Revised Code. 282

~~(T)~~(U) "Panel" means a group of providers or health care 283
facilities that have joined together to deliver health care 284
services through a contractual arrangement with a health insuring 285
corporation, employer group, or other payor. 286

~~(U)~~(V) "Person" has the same meaning as in section 1.59 of 287
the Revised Code, and, unless the context otherwise requires, 288
includes any insurance company holding a certificate of authority 289
under Title XXXIX of the Revised Code, any subsidiary and 290
affiliate of an insurance company, and any government agency. 291

~~(V)~~(W) "Premium rate" means any set fee regularly paid by a 292
subscriber to a health insuring corporation. A "premium rate" does 293

not include a one-time membership fee, an annual administrative 294
fee, or a nominal access fee, paid to a managed health care system 295
under which the recipient of health care services remains solely 296
responsible for any charges accessed for those services by the 297
provider or health care facility. 298

~~(W)~~(X) "Primary care provider" means a provider that is 299
designated by a health insuring corporation to supervise, 300
coordinate, or provide initial care or continuing care to an 301
enrollee, and that may be required by the health insuring 302
corporation to initiate a referral for specialty care and to 303
maintain supervision of the health care services rendered to the 304
enrollee. 305

~~(X)~~(Y) "Provider" means any natural person or partnership of 306
natural persons who are licensed, certified, accredited, or 307
otherwise authorized in this state to furnish health care 308
services, or any professional association organized under Chapter 309
1785. of the Revised Code, provided that nothing in this chapter 310
or other provisions of law shall be construed to preclude a health 311
insuring corporation, health care practitioner, or organized 312
health care group associated with a health insuring corporation 313
from employing certified nurse practitioners, certified nurse 314
anesthetists, clinical nurse specialists, certified nurse 315
midwives, dietitians, physician assistants, dental assistants, 316
dental hygienists, optometric technicians, or other allied health 317
personnel who are licensed, certified, accredited, or otherwise 318
authorized in this state to furnish health care services. 319

~~(Y)~~(Z) "Provider sponsored organization" means a corporation, 320
as defined in division ~~(H)~~(I) of this section, that is at least 321
eighty per cent owned or controlled by one or more hospitals, as 322
defined in section 3727.01 of the Revised Code, or one or more 323
physicians licensed to practice medicine or surgery or osteopathic 324
medicine and surgery under Chapter 4731. of the Revised Code, or 325

any combination of such physicians and hospitals. Such control is 326
presumed to exist if at least eighty per cent of the voting rights 327
or governance rights of a provider sponsored organization are 328
directly or indirectly owned, controlled, or otherwise held by any 329
combination of the physicians and hospitals described in this 330
division. 331

~~(Z)~~(AA) "Solicitation document" means the written materials 332
provided to prospective subscribers or enrollees, or both, and 333
used for advertising and marketing to induce enrollment in the 334
health care plans of a health insuring corporation. 335

~~(AA)~~(BB) "Subscriber" means a person who is responsible for 336
making payments to a health insuring corporation for participation 337
in a health care plan, or an enrollee whose employment or other 338
status is the basis of eligibility for enrollment in a health 339
insuring corporation. 340

~~(BB)~~(CC) "Urgent care services" means those health care 341
services that are appropriately provided for an unforeseen 342
condition of a kind that usually requires medical attention 343
without delay but that does not pose a threat to the life, limb, 344
or permanent health of the injured or ill person, and may include 345
such health care services provided out of the health insuring 346
corporation's approved service area pursuant to indemnity payments 347
or service agreements. 348

Sec. 3923.281. (A) As used in this section: 349

(1) ~~"Biologically based mental illness" means schizophrenia,~~ 350
~~schizoaffective disorder, major depressive disorder, bipolar~~ 351
~~disorder, paranoia and other psychotic disorders,~~ 352
~~obsessive compulsive disorder, and panic disorder, as these terms~~ 353
~~are defined in "Mental illness" means any condition or disorder~~ 354
involving mental illness as defined by the most recent edition of 355
the diagnostic and statistical manual of mental disorders 356

published by the American psychiatric association or as defined by 357
any diagnostic category listed in the mental disorder section of 358
the most recent edition of the international classification of 359
diseases. 360

(2) "Policy of sickness and accident insurance" has the same 361
meaning as in section 3923.01 of the Revised Code, but excludes 362
any hospital indemnity, medicare supplement, long-term care, 363
disability income, one-time-limited-duration policy of not longer 364
than six months, supplemental benefit, or other policy that 365
provides coverage for specific diseases or accidents only; any 366
policy that provides coverage for workers' compensation claims 367
compensable pursuant to Chapters 4121. and 4123. of the Revised 368
Code; and any policy that provides coverage to beneficiaries 369
enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 370
(1935), 42 U.S.C.A. 301, as amended, known as the medical 371
assistance program or medicaid, as provided by the Ohio department 372
of job and family services under Chapter 5111. of the Revised 373
Code. 374

(3) "Substance abuse or addiction condition" means any 375
alcohol or drug related disorder as defined by the most recent 376
edition of the diagnostic and statistical manual of mental 377
disorders published by the American psychiatric association or as 378
defined by a diagnostic category listed in the most recent edition 379
of the international classification of diseases. 380

(B) Notwithstanding section 3901.71 of the Revised Code, and 381
subject to division (E) of this section, every group policy of 382
sickness and accident insurance shall provide benefits for the 383
diagnosis and treatment of ~~biologically based~~ mental illnesses and 384
substance abuse or addiction conditions on the same terms and 385
conditions as, and shall provide benefits no less extensive than, 386
those provided under the policy of sickness and accident insurance 387
for the treatment and diagnosis of all other physical diseases and 388

disorders, if both of the following apply: 389

(1) The ~~biologically based~~ mental illness or substance abuse 390
or addiction condition is clinically diagnosed by a physician 391
authorized under Chapter 4731. of the Revised Code to practice 392
medicine and surgery or osteopathic medicine and surgery; a 393
psychologist licensed under Chapter 4732. of the Revised Code; a 394
professional clinical counselor, professional counselor, or 395
independent social worker licensed under Chapter 4757. of the 396
Revised Code; or a clinical nurse specialist licensed under 397
Chapter 4723. of the Revised Code whose nursing specialty is 398
mental health. 399

(2) The prescribed treatment is not experimental or 400
investigational, having proven its clinical effectiveness in 401
accordance with generally accepted medical standards. 402

(C) Division (B) of this section applies to all coverages and 403
terms and conditions of the policy of sickness and accident 404
insurance, including, but not limited to, coverage of inpatient 405
hospital services, outpatient services, and medication; maximum 406
lifetime benefits; copayments; and individual and family 407
deductibles. 408

(D) Nothing in this section shall be construed as prohibiting 409
a sickness and accident insurance company from taking any of the 410
following actions: 411

(1) Negotiating separately with mental health care providers 412
with regard to reimbursement rates and the delivery of health care 413
services; 414

(2) Offering policies that provide benefits solely for the 415
diagnosis and treatment of ~~biologically based~~ mental illnesses and 416
substance abuse or addiction conditions; 417

(3) Managing the provision of benefits for the diagnosis or 418
treatment of ~~biologically based~~ mental illnesses and substance 419

abuse or addiction conditions through the use of pre-admission 420
screening, by requiring beneficiaries to obtain authorization 421
prior to treatment, or through the use of any other mechanism 422
designed to limit coverage to that treatment determined to be 423
necessary; 424

(4) Enforcing the terms and conditions of a policy of 425
sickness and accident insurance. 426

(E) An insurer that offers a group policy of sickness and 427
accident insurance is not required to provide benefits for the 428
diagnosis and treatment of ~~biologically based~~ mental illnesses and 429
substance abuse or addiction conditions pursuant to division (B) 430
of this section if all of the following apply: 431

(1) The insurer submits documentation certified by an 432
independent member of the American academy of actuaries to the 433
superintendent of insurance showing that incurred claims for 434
diagnostic and treatment services for ~~biologically based~~ mental 435
illnesses and substance abuse or addiction conditions for a period 436
of at least six months independently caused the insurer's costs 437
for claims and administrative expenses for the coverage of all 438
other physical diseases and disorders to increase by more than one 439
per cent per year. 440

(2) The insurer submits a signed letter from an independent 441
member of the American academy of actuaries to the superintendent 442
of insurance opining that the increase described in division 443
(E)(1) of this section could reasonably justify an increase of 444
more than one per cent in the annual premiums or rates charged by 445
the insurer for the coverage of all other physical diseases and 446
disorders. 447

(3) The superintendent of insurance makes the following 448
determinations from the documentation and opinion submitted 449
pursuant to divisions (E)(1) and (2) of this section: 450

(a) Incurred claims for diagnostic and treatment services for 451
~~biologically based mental illnesses and substance abuse or~~ 452
~~addiction conditions~~ for a period of at least six months 453
independently caused the insurer's costs for claims and 454
administrative expenses for the coverage of all other physical 455
diseases and disorders to increase by more than one per cent per 456
year. 457

(b) The increase in costs reasonably justifies an increase of 458
more than one per cent in the annual premiums or rates charged by 459
the insurer for the coverage of all other physical diseases and 460
disorders. 461

Any determination made by the superintendent under this 462
division is subject to Chapter 119. of the Revised Code. 463

Sec. 3923.282. (A) As used in this section: 464

(1) ~~"Biologically based mental illness" means schizophrenia,~~ 465
~~schizoaffective disorder, major depressive disorder, bipolar~~ 466
~~disorder, paranoia and other psychotic disorders,~~ 467
~~obsessive compulsive disorder, and panic disorder, as these terms~~ 468
~~are defined in "Mental illness" means any condition or disorder~~ 469
involving mental illness as defined by the most recent edition of 470
the diagnostic and statistical manual of mental disorders 471
published by the American psychiatric association or as defined by 472
any diagnostic category listed in the mental disorder section of 473
the most recent edition of the international classification of 474
diseases. 475

(2) "Plan of health coverage" includes any private or public 476
employer group self-insurance plan that provides payment for 477
health care benefits for other than specific diseases or accidents 478
only, which benefits are not provided by contract with a sickness 479
and accident insurer or health insuring corporation. 480

(3) "Substance abuse or addiction condition" means any alcohol or drug related disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association or as defined by a diagnostic category listed in the most recent edition of the international classification of diseases.

(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 and substance abuse or addiction conditions 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 or substance abuse or addiction condition 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. 513

(D) This section does not apply to a plan of health coverage 514
if federal law supersedes, preempts, prohibits, or otherwise 515
precludes its application to such plans. This section does not 516
apply to long-term care, hospital indemnity, disability income, or 517
medicare supplement plans of health coverage, or to any other 518
supplemental benefit plans of health coverage. 519

(E) Nothing in this section shall be construed as prohibiting 520
an employer from taking any of the following actions in connection 521
with a plan of health coverage: 522

(1) Negotiating separately with mental health care providers 523
with regard to reimbursement rates and the delivery of health care 524
services; 525

(2) Managing the provision of benefits for the diagnosis or 526
treatment of ~~biologically based~~ mental illnesses and substance 527
abuse or addiction conditions through the use of pre-admission 528
screening, by requiring beneficiaries to obtain authorization 529
prior to treatment, or through the use of any other mechanism 530
designed to limit coverage to that treatment determined to be 531
necessary; 532

(3) Enforcing the terms and conditions of a plan of health 533
coverage. 534

(F) An employer that offers a plan of health coverage is not 535
required to provide benefits for the diagnosis and treatment of 536
~~biologically based~~ mental illnesses and substance abuse or 537
addiction conditions in combination with benefits for the 538
treatment and diagnosis of all other physical diseases and 539
disorders as described in division (B) of this section if both of 540
the following apply: 541

(1) The employer submits documentation certified by an 542
independent member of the American academy of actuaries to the 543

superintendent of insurance showing that incurred claims for 544
diagnostic and treatment services for ~~biologically based~~ mental 545
illnesses and substance abuse or addiction conditions for a period 546
of at least six months independently caused the employer's costs 547
for claims and administrative expenses for the coverage of all 548
other physical diseases and disorders to increase by more than one 549
per cent per year. 550

(2) The superintendent of insurance determines from the 551
documentation and opinion submitted pursuant to division (F) of 552
this section, that incurred claims for diagnostic and treatment 553
services for ~~biologically based~~ mental illnesses and substance 554
abuse or addiction conditions for a period of at least six months 555
independently caused the employer's costs for claims and 556
administrative expenses for the coverage of all other physical 557
diseases and disorders to increase by more than one per cent per 558
year. 559

Any determination made by the superintendent under this 560
division is subject to Chapter 119. of the Revised Code. 561

Sec. 3923.51. (A) As used in this section, "official poverty 562
line" means the poverty line as defined by the United States 563
office of management and budget and revised by the secretary of 564
health and human services under 95 Stat. 511, 42 U.S.C.A. 9902, as 565
amended. 566

(B) Every insurer that is authorized to write sickness and 567
accident insurance in this state may offer group contracts of 568
sickness and accident insurance to any charitable foundation that 569
is certified as exempt from taxation under section 501(c)(3) of 570
the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 571
1, as amended, and that has the sole purpose of issuing 572
certificates of coverage under these contracts to persons under 573
the age of nineteen who are members of families that have incomes 574

that are no greater than three hundred per cent of the official 575
poverty line. 576

(C) Contracts offered pursuant to division (B) of this 577
section are not subject to any of the following: 578

(1) Sections 3923.122, 3923.24, ~~3923.28~~, and 3923.281, ~~and~~ 579
~~3923.29~~ of the Revised Code; 580

(2) Any other sickness and accident insurance coverage 581
required under this chapter on August 3, 1989. Any requirement of 582
sickness and accident insurance coverage enacted after that date 583
applies to this section only if the subsequent enactment 584
specifically refers to this section. 585

(3) Chapter 1751. of the Revised Code. 586

Section 2. That existing sections 1739.05, 1751.01, 3923.281, 587
3923.282, and 3923.51 and sections 3923.28, 3923.29, and 3923.30 588
of the Revised Code are hereby repealed. 589