As Introduced

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Senator Seitz

Cosponsors: Senators Balderson, Eklund, Patton, LaRose, Manning

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A B I L L

To amend sections 1751.01, 3923.281, and 3923.282 of the Revised Code to include pervasive developmental disorders in the mental health insurance parity law. 1 2 3 4

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

Section 1. That sections 1751.01, 3923.281, and 3923.282 of the Revised Code be amended to read as follows: 5 6

Sec. 1751.01. As used in this chapter: 7

(A)(1) "Basic health care services" means the following services when medically necessary: 8 9

(a) Physician's services, except when such services are supplemental under division (B) of this section; 10 11

(b) Inpatient hospital services; 12

(c) Outpatient medical services; 13

(d) Emergency health services; 14

(e) Urgent care services; 15

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services; 16 17

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses; 18 19 20

(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; 21 22 23 24

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code. 25 26 27

"Basic health care services" does not include experimental procedures. 28 29

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 medicare 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 medicaid recipients, 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. 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45

(2)(a) 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 46 47 48

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.

(b) Coverage for diagnostic and treatment services for biologically based mental illnesses related to pervasive developmental disorders shall include applied behavior analysis when provided or supervised by an analyst certified by the behavior analyst certification board or by a state licensed physician or psychologist, or a mental health professional, as defined in division (A)(1)(d) of section 2305.51 of the Revised Code, so long as the services performed are commensurate with the physician's, psychologist's, or mental health professional's training and supervised experience. Such coverage shall include the services of the personnel who work under the supervision of the analyst certified by the behavior analyst certification board or the licensed physician or psychologist or the mental health professional.

(c) A health insuring corporation may subject coverage for applied behavior analysis to an annual maximum benefit of fifty thousand dollars.

(d) On and after January 1, 2014, to the extent that division (A)(2)(b) of this section results in the state paying the cost of benefits that exceed the essential health benefits specified under section 1302(b) of the "Patient Protection and Affordable Care Act," 42 U.S.C. 18022(b), as amended, those benefits that exceed the specified essential health benefits shall not be required of health benefit plans in the individual market or in the small

group market that are offered by a health insuring corporation in this state either through or outside a health insurance exchange operated by the state or by the federal government. 81 82 83

(e) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, that is delivered in a home or clinic setting to address core deficits resulting from a medical diagnosis of pervasive developmental disorder. "Applied behavior analysis" includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. 84 85 86 87 88 89 90 91 92

(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: 93 94 95 96 97

(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. 98 99 100 101 102 103 104 105 106

(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 107 108 109 110 111 112

the coverage of basic health care services. 113

(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: 114 115 116

(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. 117 118 119 120 121 122

(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. 123 124 125 126

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 127 128

(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: 129 130 131 132 133

(a) Services of facilities for intermediate or long-term care, or both; 134 135

(b) Dental care services; 136

(c) Vision care and optometric services including lenses and frames; 137 138

(d) Podiatric care or foot care services; 139

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses; 140 141

(f) Short-term outpatient evaluative and crisis-intervention 142

mental health services; 143

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; 144 145

(h) Home health services; 146

(i) Prescription drug services; 147

(j) Nursing services; 148

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code; 149 150

(l) Physical therapy services; 151

(m) Chiropractic services; 152

(n) Any other category of services approved by the superintendent of insurance. 153 154

(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. 155 156 157 158 159

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) 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. 160 161 162 163 164

(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, and pervasive developmental disorders. 165 166 167 168 169 170 171 172

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers. 173 174

(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. 175 176 177

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation. 178 179 180

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state. 181 182 183

(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. 184 185 186 187 188 189 190

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation. 191 192 193

(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. 194 195 196 197

(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. 198 199 200 201 202

(M) "Health care services" means basic, supplemental, and specialty health care services. 203 204

(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. 205 206 207 208

(O) "Health insuring corporation" means a corporation, as defined in division (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. 209 210 211 212 213 214 215 216 217

"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 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. 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234

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. 235 236 237 238

(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. 239 240 241 242 243 244 245

(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. 246 247 248 249

(R) "Medicaid" has the same meaning as in section 5111.01 of the Revised Code. 250 251

(S) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment. 252 253 254

(T) "Medicare" means the program established under Title XVIII of the "Social Security Act" 49 Stat. 620 (1935), 42 U.S.C. 1395, as amended. 255 256 257

(U)(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. 258 259 260 261

(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 262 263 264 265

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. 266 267 268 269 270 271

(V) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following: 272 273 274 275

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician; 276 277 278 279

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians; 280 281

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members. 282 283

(W) "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. 284 285 286 287

(X) "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. 288 289 290 291 292

(Y) "Pervasive developmental disorder" means all of the following as they are defined in the most recent edition of the diagnostic and statistical manual of mental disorders as published by the American psychiatric association: 293 294 295 296

(1) Autistic disorder;

(2) Asperger's disorder;

(3) Pervasive developmental disorder-not otherwise specified;

(4) Rett's syndrome;

(5) Childhood disintegrative disorder.

(Z) "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.

~~(Z)~~(AA) "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.

~~(AA)~~(BB) "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. 328 329

~~(BB)~~(CC) "Provider sponsored organization" means a corporation, as defined in division (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. 330 331 332 333 334 335 336 337 338 339 340 341

~~(CC)~~(DD) "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. 342 343 344 345

~~(DD)~~(EE) "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. 346 347 348 349 350

~~(EE)~~(FF) "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. 351 352 353 354 355 356 357 358

Sec. 3923.281. (A) As used in this section: 359

(1) "Biologically based mental illness" means schizophrenia, 360
schizoaffective disorder, major depressive disorder, bipolar 361
disorder, paranoia and other psychotic disorders, 362
obsessive-compulsive disorder, and panic disorder, as these terms 363
are defined in the most recent edition of the diagnostic and 364
statistical manual of mental disorders published by the American 365
psychiatric association, and pervasive developmental disorders. 366

(2) "Policy of sickness and accident insurance" has the same 367
meaning as in section 3923.01 of the Revised Code, but excludes 368
any hospital indemnity, medicare supplement, long-term care, 369
disability income, one-time-limited-duration policy of not longer 370
than six months, supplemental benefit, or other policy that 371
provides coverage for specific diseases or accidents only; any 372
policy that provides coverage for workers' compensation claims 373
compensable pursuant to Chapters 4121. and 4123. of the Revised 374
Code; and any policy that provides coverage to beneficiaries 375
enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 376
(1935), 42 U.S.C.A. 301, as amended, known as the medical 377
assistance program or medicaid, as provided by the Ohio department 378
of job and family services under Chapter 5111. of the Revised 379
Code. 380

(3) "Applied behavior analysis" means the design, 381
implementation, and evaluation of environmental modifications 382
using behavioral stimuli and consequences to produce socially 383
significant improvement in human behavior, that is delivered in a 384
home or clinic setting to address core deficits resulting from a 385
medical diagnosis of pervasive developmental disorder. "Applied 386
behavior analysis" includes the use of direct observation, 387
measurement, and functional analysis of the relationship between 388
environment and behavior. 389

(4) "Pervasive developmental disorder" means all of the 390
following as they are defined in the most recent edition of the 391
diagnostic and statistical manual of mental disorders as published 392
by the American psychiatric association: 393

(a) Autistic disorder; 394

(b) Asperger's disorder; 395

(c) Pervasive developmental disorder-not otherwise specified; 396

(d) Rett's syndrome; 397

(e) Childhood disintegrative disorder. 398

(B)(1) Notwithstanding section 3901.71 of the Revised Code, 399
and subject to division (E) of this section, every policy of 400
sickness and accident insurance shall provide benefits for the 401
diagnosis and treatment of biologically based mental illnesses on 402
the same terms and conditions as, and shall provide benefits no 403
less extensive than, those provided under the policy of sickness 404
and accident insurance for the treatment and diagnosis of all 405
other physical diseases and disorders, if both of the following 406
apply: 407

~~(1)~~(a) The biologically based mental illness is clinically 408
diagnosed by a physician authorized under Chapter 4731. of the 409
Revised Code to practice medicine and surgery or osteopathic 410
medicine and surgery; a psychologist licensed under Chapter 4732. 411
of the Revised Code; a professional clinical counselor, 412
professional counselor, or independent social worker licensed 413
under Chapter 4757. of the Revised Code; or a clinical nurse 414
specialist licensed under Chapter 4723. of the Revised Code whose 415
nursing specialty is mental health. 416

~~(2)~~(b) The prescribed treatment is not experimental or 417
investigational, having proven its clinical effectiveness in 418
accordance with generally accepted medical standards. 419

(2) Coverage for diagnostic and treatment services for biologically based mental illnesses related to pervasive developmental disorders shall include applied behavior analysis when provided or supervised by an analyst certified by the behavior analyst certification board or by a state licensed physician or psychologist, or a mental health professional, as defined under division (A)(1)(d) of section 2305.51 of the Revised Code, so long as the services performed are commensurate with the physician's, psychologist's, or mental health professional's training and supervised experience. Such coverage shall include the services of the personnel who work under the supervision of the analyst certified by the behavior analyst certification board or the licensed physician or psychologist or the mental health professional. 420 421 422 423 424 425 426 427 428 429 430 431 432 433

(3) An insurer may subject coverage for applied behavior analysis to an annual maximum benefit of fifty thousand dollars. 434 435

(4) On and after January 1, 2014, to the extent that the requirement of division (B)(2) of this section results in the state paying the cost of benefits that exceed the essential health benefits specified under section 1302(b) of the "Patient Protection and Affordable Care Act," 42 U.S.C. 300gg-11, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of health benefit plans in the individual market or the small group market that are offered by a health care insurer in this state either through or outside a health insurance exchange operated by the state or by the federal government. 436 437 438 439 440 441 442 443 444 445 446

(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 447 448 449 450 451

deductibles. 452

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions: 453 454 455

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; 456 457 458

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses; 459 460

(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; 461 462 463 464 465 466

(4) Enforcing the terms and conditions of a policy of sickness and accident insurance. 467 468

(E) An insurer that offers any 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: 469 470 471 472 473

(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. 474 475 476 477 478 479 480 481

(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. 482 483 484 485 486 487 488

(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: 489 490 491

(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. 492 493 494 495 496 497

(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. 498 499 500 501

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 502 503

Sec. 3923.282. (A) As used in this section: 504

(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, and pervasive developmental disorders. 505 506 507 508 509 510 511

(2) "Plan of health coverage" includes any private or public 512
employer group self-insurance plan that provides payment for 513
health care benefits for other than specific diseases or accidents 514
only, which benefits are not provided by contract with a sickness 515
and accident insurer or health insuring corporation. 516

(3) "Applied behavior analysis" means the design, 517
implementation, and evaluation of environmental modifications 518
using behavioral stimuli and consequences to produce socially 519
significant improvement in human behavior, that is delivered in a 520
home or clinic setting to address core deficits resulting from a 521
medical diagnosis of pervasive developmental disorder. "Applied 522
behavior analysis" includes the use of direct observation, 523
measurement, and functional analysis of the relationship between 524
environment and behavior. 525

(4) "Pervasive developmental disorder" means all of the 526
following as they are defined in the most recent edition of the 527
diagnostic and statistical manual of mental disorders as published 528
by the American psychiatric association: 529

(a) Autistic disorder; 530

(b) Asperger's disorder; 531

(c) Pervasive developmental disorder-not otherwise specified; 532

(d) Rett's syndrome; 533

(e) Childhood disintegrative disorder. 534

(B)(1) Notwithstanding section 3901.71 of the Revised Code, 535
and subject to division (F) of this section, each plan of health 536
coverage shall provide benefits for the diagnosis and treatment of 537
biologically based mental illnesses on the same terms and 538
conditions as, and shall provide benefits no less extensive than, 539
those provided under the plan of health coverage for the treatment 540
and diagnosis of all other physical diseases and disorders, if 541

both of the following apply: 542

~~(1)~~(a) 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. 543 544 545 546 547 548 549 550 551

~~(2)~~(b) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards. 552 553 554

(2) Coverage for diagnostic and treatment services for biologically based mental illnesses related to pervasive developmental disorders shall include applied behavior analysis when provided or supervised by an analyst certified by the behavior analyst certification board or by a state licensed physician or psychologist, or a mental health professional, as defined under division (A)(1)(d) of section 2305.51 of the Revised Code, so long as the services performed are commensurate with the physician's, psychologist's, or mental health professional's training and supervised experience. Such coverage shall include the services of the personnel who work under the supervision of the analyst certified by the behavior analyst certification board or the licensed physician or psychologist or the mental health professional. 555 556 557 558 559 560 561 562 563 564 565 566 567 568

(3) An employer may subject coverage for applied behavior analysis to an annual maximum benefit of fifty thousand dollars. 569 570

(4) On and after January 1, 2014, to the extent that the requirement of division (B)(2) of this section results in the 571 572

state paying the cost of benefits that exceed the essential health benefits specified under section 1302(b) of the "Patient Protection and Affordable Care Act," 42 U.S.C. 300gg-11, as amended, the specific benefits that exceed the specified essential health benefits shall not be required of health benefit plans in the individual market or small group market that are offered by a health care insurer in this state either through or outside a health insurance exchange operated by the state or by the federal government. 573 574 575 576 577 578 579 580 581

(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. 582 583 584 585 586

(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. 587 588 589 590 591 592

(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: 593 594 595

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; 596 597 598

(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 599 600 601 602 603

to be necessary; 604

(3) Enforcing the terms and conditions of a plan of health coverage. 605 606

(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: 607 608 609 610 611 612

(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. 613 614 615 616 617 618 619 620

(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. 621 622 623 624 625 626 627 628

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code. 629 630

Section 2. That existing sections 1751.01, 3923.281, and 3923.282 of the Revised Code are hereby repealed. 631 632