Elizabeth Dominic *Legislative Service Commission*

Sub. S.B. 116*

126th General Assembly
(As Reported by S. Insurance, Commerce, & Labor)

Sens. Spada, Gardner, Schuring, Hottinger, Fedor, Fingerhut, Miller, Hagan, Dann, Zurz

BILL SUMMARY

- Prohibits discrimination in the coverage provided for the diagnosis, care, and treatment of biologically based mental illnesses in sickness and accident insurance policies and in private and public employer self-insurance plans, with certain exceptions.

- Includes biologically based mental illnesses as part of the definition of "basic health care services" for purposes of the health insuring corporation law, thereby requiring all health insuring corporations that offer coverage for basic health care services to offer like coverage for these services, with certain exceptions.

- Permits mental health services that must be provided by a licensed physician or psychologist in order to be included in certain health insurance coverage requirements to be provided by a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker.

* *This analysis was prepared before the report of the Senate Insurance, Commerce, and Labor Committee appeared in the Senate Journal. Note that the list of co-sponsors and the legislative history may be incomplete.*

CONTENT AND OPERATION

Group policies of sickness and accident insurance and employer self-insurance plans

(R.C. 3923.281 and 3923.282)

Equal benefits mandate

The bill provides that if certain conditions are met every group policy of sickness and accident insurance and every (employer self-insurance) plan of health coverage must provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as, with benefits no less extensive than, those provided under the policy or plan for the diagnosis and treatment of all other physical diseases and disorders. A "plan of health coverage" includes any private or public employer group self-insurance plan that provides payment for health care benefits for other than specific diseases or accidents only, which benefits are not provided by contract with a sickness and accident insurer or health insuring corporation. For purposes of the bill, a "policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both, but excludes all of the following: (1) a hospital indemnity policy, (2) a Medicare supplement policy, (3) a long-term care policy, (4) a disability income policy, (5) a one-time-limited-duration policy of not longer than six months, (6) a supplemental benefit policy, (7) a policy that provides coverage for specific diseases or accidents only, (8) a policy that provides coverage for workers' compensation claims compensable under the Revised Code, (9) a policy that provides coverage to beneficiaries enrolled in the Ohio Medicaid Program, and (10) any policy or certificate of sickness and accident insurance that is underwritten by an insurer on an individual basis.

The bill defines "biologically based mental illnesses" as 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.

The bill specifies that its equal benefits mandate applies to all coverages and terms and conditions of a policy of sickness and accident insurance or a 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.

The bill exempts its equal benefits mandate from the review otherwise required by R.C. 3901.71, which requires the Superintendent of Insurance to hold a public hearing to consider any new health benefit mandate contained in a law enacted by the General Assembly. A new health benefit mandate may not be applied to policies and plans of insurance until the Superintendent determines that the mandate can be fully and equally applied to self-insured employee benefit plans subject to regulation under the federal Employee Retirement Income Security Act of 1974 (ERISA), and to employee benefit plans established by the state or its political subdivisions, or their agencies and instrumentalities. ERISA generally precludes state regulation of benefits offered by private self-insured, employee benefit plans.

Conditions

Under the bill, equal benefits need not be provided for the diagnosis and treatment of biologically based mental illnesses unless the condition is clinically diagnosed by a licensed physician, psychologist, professional clinical counselor, professional counselor, independent social worker, or clinical nurse specialist with a mental health specialty. Further, equal benefits need not be provided if a prescribed treatment is experimental or investigational--the treatment must have proven its clinical effectiveness in accordance with generally accepted medical standards.

Additionally, an insurer that offers a group policy of sickness and accident insurance or a plan of health coverage or an employer if the plan is self-insured is not required to provide equal benefits under the bill if all of the conditions are met:

(1) The insurer or an employer if the plan is self-insured 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 or the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year.

(2) The insurer submits a signed letter from an independent member of the American Academy of Actuaries to the Superintendent of Insurance opining that the increase in costs could reasonably justify an increase of more than 1% in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders. If a plan is self-insured, the employer is not required to submit a letter as described above.

(3) The Superintendent of Insurance determines, from the documentation and opinions submitted, that the 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 or the employer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than 1% per year, that the increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the insurer for the coverage of all diseases and disorders.

The bill declares any such determination made pursuant to the Administrative Procedure Act (R.C. Chapter 119.) by the Superintendent of Insurance to be final.

The bill's equal benefits mandate does not apply to policies of sickness and accident insurance providing coverage for long-term care, hospital indemnity, disability income, Medicare supplement, or any other supplemental benefits. The equal benefits mandate does not apply to a plan of health coverage if federal law supersedes, preempts, prohibits, or otherwise precludes its application.

Construction of mandate

The bill specifies that its provisions do not prohibit an employer from doing any of the following: (1) negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services, (2) managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or though the use of another mechanism designed to limit coverage to treatment determined to be necessary, or (3) enforcing the terms and conditions of a policy or plan. The bill also states that its provisions do not prohibit a sickness and accident insurer from offering policies providing benefits solely for the diagnosis and treatment of biologically based mental illnesses.

Policies, contracts, and agreements of health insuring corporations

(R.C. 1751.01)

Under current law, a health insuring corporation is prohibited from offering coverage for a health care service defined by the Revised Code as a basic health care service unless it offers coverage for all basic health care services as listed in the statute.[1] Diagnostic and treatment services for biologically based mental illnesses are not included as basic health care services.

[1] *A health insuring corporation is a corporation, such as a health maintenance organization (HMO), that provides health care services through a panel of participating providers.*

The bill amends the definition of "basic health care services" in the health insuring corporation law to include diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses as basic health care services. The effect of this amendment is to require all health insuring corporations offering coverage for basic health care services to offer coverage for biologically based mental illnesses. Diagnostic and treatment services for biologically based mental illnesses are specifically excluded from the list of services in the health insuring corporation law's definition of "supplemental health care services," a list providing types of 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. The effect is to retain "mental health services" currently in existing law as one type of supplemental health care service but to limit that phrase to something that is not a biologically based mental illness.

Notwithstanding the requirement that all health insuring corporations offering coverage for basic health care services must offer coverage for biologically based mental illnesses, the bill permits a health insuring corporation to do the following: (1) offer coverage for diagnostic and treatment services for biologically based mental illnesses alone without offering coverage for all other basic health care services, and (2) offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more *supplemental* health care services. Additionally, notwithstanding the bill's equal benefits mandate, a health insuring corporation that offers coverage for basic health care services is not required to offer coverage for biologically based mental illnesses in combination with the offer, when all of the following conditions are met:

(1) 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 1% per year.

(2) 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 could reasonably justify an increase of more than 1% in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3) The Superintendent of Insurance determines, from the documentation and opinions submitted, that the 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 1% per year, and that the increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

The bill declares any such determination made pursuant to the Administrative Procedure Act by the Superintendent of Insurance to be final.

Certain provisions of the health insuring corporation law (Revised Code Chapters 1751. and 1753.) are applicable only to a health insuring corporation's provision of basic health care services. Such provisions include, but are not limited to, a limitation on copayments, a prohibition on maximum lifetime benefits, and the implementation of a quality assurance program. Biologically based mental illnesses, included in a policy, plan, or agreement as part of basic health care services, are subject to these provisions.

Existing mandates for treatment of mental or emotional disorders

(R.C. 1739.05, 3923.28, and 3923.51)

Existing law requires those group policies of sickness and accident insurance providing coverage for other than specific diseases or accidents only, which policies specifically provide coverage for mental or emotional disorders, to provide outpatient treatment benefits equal to at least $550 annually. Similar benefit requirements apply to self-insured health care plans, including those offered by the state and its political subdivisions and their instrumentalities. The bill provides that these benefits for mental and emotional disorders cannot be reduced by the benefits for diagnostic and treatment services for biologically based mental illnesses required by the bill.

Also under existing law, for services to be covered by the $550 annual coverage requirement they must be performed by, or under the supervision of, a licensed physician or psychologist. The bill provides that the services also may be provided by a clinical nurse specialist whose nursing specialty is mental health or by a professional clinical counselor, professional counselor, or independent social worker.

Application of the bill

(Section 3)

The bill applies to health insuring corporation policies, contracts, and agreements delivered, issued for delivery, or renewed in Ohio six months after the

bill's effective date; sickness and accident insurance policies six months after the bill's effective date; self-insurance plans established or modified in Ohio six months after the bill's effective date; and public employee health plans established or modified in Ohio six months after the bill's effective date.

HISTORY

ACTION	DATE
Introduced	04-01-05
Reported, S. Insurance, Commerce, & Labor	---

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