



S.B. 298

127th General Assembly
(As Introduced)

Sens. D. Miller, Roberts, Fedor, R. Miller, Bocchieri, Smith

BILL SUMMARY

- Prohibits discrimination in health care policies, contracts, and agreements in the coverage provided for the diagnosis and treatment of mental illnesses and substance abuse or addiction conditions.

CONTENT AND OPERATION

Current law

Coverage for biologically based mental illnesses

Current law requires policies of sickness and accident insurance and private or public employer group self-insurance plans to provide benefits for the diagnosis and treatment of biologically based mental illnesses on the same terms and conditions as those provided under the policy for the diagnosis and treatment of all other physical diseases and disorders, but only if the mental illness is clinically diagnosed by a specified health care professional and the treatment is not experimental (R.C. 3923.281 and 3923.282). Current law also requires health insuring corporations to cover the diagnosis and treatment of biologically based mental illnesses as a basic health care service. The health insuring corporation generally may not provide coverage for any other basic health care services without providing coverage for the diagnosis and treatment of biologically based mental illnesses. However, a health insuring corporation may provide supplemental coverage for the diagnosis and treatment of biologically based mental illnesses without providing coverage for the other basic health care services. (R.C. 1751.01.)

Under current law, the coverage detailed above is not required if all of the following conditions are met:

(1) The insurer, employer, or 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 insurer's or 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) In the case of an insurer or health insuring corporation, the insurer or 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 insurer or health insuring corporation for the coverage of all other physical diseases and disorders. An employer is not required to submit such a letter.

(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, employer's, or health insuring corporation'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 and the increase in costs reasonably justifies an increase of more than 1% in the annual premiums or rates charged by the insurer or health insuring corporation for the coverage of all diseases and disorders.

The law provides that any such determination made by the Superintendent of Insurance is subject to the Administrative Procedure Act (R.C. Chapter 119.). (R.C. 1751.01, 3923.281, and 3923.282.)

Coverage for mental or emotional disorders and alcoholism treatment

Current law requires group policies of sickness and accident insurance and private or public employer group insurance plans that specifically provide coverage for mental or emotional disorders to provide outpatient treatment benefits equal to at least \$550 annually subject to reasonable limitations, deductibles, and co-insurance. Current law also requires group policies of sickness and accident insurance and private or public employer group insurance plans to provide coverage for alcoholism treatment for outpatient, inpatient, and intermediate primary care at least equal to \$550 in any calendar year subject to reasonable limitations, deductibles, and co-insurance. (Repealed R.C. 3923.28, 3923.29, and 3923.30.)

Operation of the bill

The bill repeals the separate current requirements for coverage of mental and emotional disorders and alcohol addiction treatment (R.C. 3923.28, 3923.29, and 3923.30) and instead adds coverage for these types of disorders to current law's requirements for coverage of "biologically based" mental illnesses. The bill, however, also removes from the law the requirement that covered illnesses be "biologically based" and requires policies of sickness and accident insurance, private or public employer group self-insurance plans, and contracts or policies of health insuring corporations to provide coverage for all "mental illnesses." The bill also includes in the revised requirement the same coverage for "substance abuse and addiction conditions." (R.C. 1751.01, 3923.281, and 3923.282.)

The bill defines "mental illness" as "any condition or disorder involving mental illness 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 any diagnostic category listed in the mental disorder section of the most recent edition of the *International Classification of Diseases*." The bill defines "substance abuse or addiction condition" as "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*." (R.C. 1751.01, 3923.281, and 3923.282.)

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Am. Sub. H.B. 478 of the 119th General Assembly provides that no mandated health benefits legislation enacted on or after January 14, 1993, can apply to any health benefits arrangement until the Superintendent of Insurance holds a public hearing and determines that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or its political subdivisions.¹ (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction (R.C. 2923.281(B) and 3923.282(B)).

¹ ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from an insurer or health insuring corporation.

COMMENT

The benefits required by the bill may be considered "mandated benefits."² Pursuant to Sub. H.B. 405 of the 124th General Assembly, the chairperson of a standing committee of either house may, at any time, request that the Director of the Legislative Service Commission review any bill assigned to the chairperson's committee to determine whether the bill includes a mandated benefit. If the Director determines that the bill includes a mandated benefit, the presiding officer of the house that is considering the bill may request the Director to arrange for the performance of an independent healthcare actuarial review of the benefit. Not later than 60 days after the presiding officer's request for a review, the Director must submit the findings of the actuarial review to the chairperson of the committee to which the bill is assigned and to the ranking minority member of that committee. (R.C. 103.144 to 103.146, not in the bill.)

HISTORY

ACTION	DATE
Introduced	02-26-08

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² "Mandated benefit" means the following, considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: (1) any required coverage for a specific medical or health-related service, treatment, medication, or practice, (2) any required coverage for the services of specific health care providers, (3) any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups, (4) any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees, (5) any required expansion of, or addition to, existing coverage, and (6) any mandated reimbursement amount to specific health care providers (R.C. 103.144, not in the bill).