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Bill Analysis

Version: As Introduced

Primary Sponsor: Sen. Williams

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SUMMARY

- Prohibits health plan issuers from imposing a cost-sharing requirement for biologically based mental illnesses or for mental or emotional disorders that is separate from the cost-sharing requirement for standard health services.
- Requires a health plan that considers a provider as being "in-network" for standard health services to also consider that provider as being in-network for services related to biologically based mental illnesses or mental or emotional disorders, so long as the provider is qualified to provide such services.

DETAILED ANALYSIS

Overview

The bill imposes parity requirements on health plan issuers that offer coverage for biologically based mental illnesses and mental or emotional disorders. Under current law, unchanged by the bill, "biologically based mental illness" is defined as being schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder.[1] The bill applies to all of the following types of health plan issuers:

- Health insuring corporations;
- Sickness and accident insurers;
- Multiple employee welfare arrangements;

[1] R.C. 1751.01(D), 3923.281(A)(1), and 3923.282(A)(1), not in the bill.

- Public or private group self-insurance benefit plans.[2]

Cost-sharing requirements

The bill prohibits a health plan issuer that provides coverage for biologically based mental illnesses and for mental or emotional disorders from imposing a cost sharing requirement for those illnesses that is separate from the cost sharing requirement that applies to standard medical insurance coverage.[3] Under current law, health benefit plans are required to provide coverage for biologically based mental illnesses on the same terms and conditions as the plan covers standard health benefits, generally referred to as "mental health parity."[4] Note, however, that these mental health parity requirements appear to have been sometimes interpreted as allowing health benefit plans to impose *separate* coverage limitations or requirements, so long as such limitations or requirements are fundamentally equal. For example, a health benefit plan that requires a $1,000 deductible for standard health benefits may charge a separate deductible for biologically based mental illnesses of up to $1,000. Such a health benefit plan is not required to have the same $1,000 for both types of coverage. Under the bill, the health plan could only have a single deductible of $1,000 for all coverage types.

Network requirements

The bill requires health plan issuers to consider health care providers that are in-network with regard to basic health care services as also being in-network with regard to services for biologically based mental illnesses and for mental or emotional disorders, so long as the provider is qualified to provide such services.[5]

To provide an example, under current law, a health care provider that is qualified to prescribe prescription drugs for both standard illnesses and biologically based mental illnesses might be considered in network by a covered individual's health plan for only the standard illnesses. In such a situation, the covered individual would have to see a separate provider to receive a prescription for the biologically based mental illness or pay the related out-of-network costs.

Exemption from review by the Superintendent of Insurance

The bill might be considered to mandate health benefits. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974," (ERISA),[6] and to

[2] R.C. 1739.05, 1751.011, and 3923.283 and R.C. 3923.282, not in the bill.

[3] R.C. 1739.05, 1751.011(B)(1), and 3923.283(B)(1).

[4] R.C. 1751.01, 3923.281, and 3923.282.

[5] R.C. 1739.05, 1751.011(B)(2), and 3923.283(B)(2).

[6] 29 United States Code (U.S.C.) 1001, as amended.

employee benefit plans established or modified by the state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.[7] The bill contains provisions that exempt its requirements from this restriction.

HISTORY

Action	Date
Introduced	11-20-19

S0241-I-133/ts

[7] 29 U.S.C. 1144.