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Bill Analysis

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Primary Sponsors: Reps. Plummer and Russo

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UPDATED VERSION

SUMMARY

- Repeals state law provisions requiring sickness and accident insurers and self-insured plans to cover biologically based mental illness and to ensure such coverage is equal to the coverage provided for standard health benefits.
- Requires health benefit plans to comply with Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
- Repeals certain alcohol treatment coverage minimum requirements that apply to sickness and accident insurers and self-insured plans.
- Repeals a prohibition relating to insurers excluding coverage of hospitalization for mental illness for the reason that the hospitalization is at a tax-supported facility as long as the facility is accredited.
- Amends the Health Insuring Corporation Law in relation to mental health benefits.
- Requires health benefit plans subject to the MHPAEA to report to the Superintendent of Insurance or Department of Medicaid, as applicable, on parity compliance.
- Prohibits certain coverage limitations for health benefit plans subject to the MHPAEA for drugs prescribed in relation to a substance use disorder.
- Requires the Superintendent of Insurance to produce an annual report on MHPAEA enforcement.
- Requires the Department of Medicaid to produce a biennial report on MHPAEA compliance.

DETAILED ANALYSIS

Overview

The bill repeals state law provisions requiring parity between standard medical benefits and mental health benefits (generally referred to as mental health parity) in favor of the federal mental health parity law, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The bill also repeals certain mental health and addiction coverage minimums that apply to sickness and accident insurers and self-insured benefit plans.

Current law

Current mental health law is the result of the interaction between federal and state law. The following is an explanation of that interaction.

Federal law

Under the Patient Protection and Affordable Care Act of 2010 (ACA), small group and individual plans are required to provide mental health coverage and mental health parity.[1] Large group and self-insured plans are NOT required to provide mental health services coverage.[2] However, under the MHPAEA, if a large group plan *does* offer mental health coverage, then it must also provide mental health parity.[3] Under the MHPAEA, the term "mental health condition" is defined under the terms of the plan and in accordance with applicable federal and state law.[4]

State law

Under current state law, health insuring corporations, sickness and accident insurers, public self-insured plans, and multiple employer welfare arrangements are required to provide coverage for biologically based mental illness, which, unlike federal law, is limited to the following:

- Schizophrenia;
- Schizoaffective disorder;
- Major depressive disorder;
- Bipolar disorder;
- Paranoia and other psychotic disorders;

[1] 42 United States Code (U.S.C.) 300gg-6(a), 42 U.S.C. 18022(b)(1)(e), and 42 U.S.C. 18031(d)(4).

[2] 45 Code of Federal Regulations (C.F.R.) 147.150(a); see also Federal Register Vol. 78, No. 37, footnote 64.

[3] 29 U.S.C. 1185a(c).

[4] R.C. 1751.01(D) and 29 U.S.C. 1185a(e)(4).

- Obsessive-compulsive disorder;
- Panic disorder.

These health benefit plans are also required to provide parity between these benefits and standard health benefits.[5]

Thus, under current federal and state law, the following types of plans are required to provide some sort of mental health coverage *and* mental health parity:

- Purchased individual plans;
- Purchased small group plans;
- Large group purchased plans;
- Public self-insured plans;
- Multiple employer welfare arrangements.

Sickness and accident insurers and self-insured plans

The bill repeals certain mental health and addiction services requirements with regard to sickness and accident insurers and self-insured plans. The following is a brief summary of those provisions:

- Requirements prohibiting insurers providing coverage of hospitalization for mental illness from excluding coverage for the reason that the hospitalization is at a tax-supported facility as long as the facility is accredited and regulating the amount of the coverage;[6]
- Minimum coverage levels for outpatient mental or emotional disorder services, or for evaluations, if mental or emotional disorder services are covered;[7]
- Mandated coverage for biologically based mental illnesses and related parity requirements;[8]
- Minimum coverage levels of $550 per year for outpatient, inpatient, and intermediate primary care alcoholism services in all sickness and accident insurance policies and both public and private self-insured benefit plans.[9]

With regard to the mandated coverage provisions that are repealed, small group and individual policies would still likely be required to offer comparable coverage under federal law.

[5] R.C. 1739.05, 1751.01, 3923.281, and 3923.282.

[6] R.C. 3923.27, repealed.

[7] R.C. 3923.28 and 3923.30, repealed; and R.C. 1739.05.

[8] R.C. 3923.281 and 3923.282, repealed; and R.C. 1739.05.

[9] R.C. 3923.29 and 3923.30, repealed; and R.C. 1739.05.

To explain, the ACA requires all small group and individual policies to cover essential health benefits, which include mental health and substance use services and for such coverage to have parity with regard to standard health services.[10]

However, this does not appear to be the case for large group plans purchased through a sickness and accident insurer and self-insured plans. Those plans are NOT required by federal law to provide coverage for essential health benefits.[11] Thus, as a result of the repeals, large group purchased plans, public self-insured plans, and multiple employer welfare arrangements would no longer be required to provide coverage for biologically based mental illness, nor would they be required to provide minimum coverage of $550 for alcoholism treatment.

Health insuring corporations

The bill amends the law pertaining to health insuring corporations (HICs) and the coverage of mental health and addiction services. Under current law, a HIC is required to provide coverage for mental health and addiction services for biologically based mental illnesses, excluding prescription drug coverage, if the HIC provides coverage for any other basic health service unless the HIC can demonstrate that such coverage has resulted in an increase in claims expenses which would result in a premium increase of more than 1% in comparison to the previous year. The bill removes this exemption.[12]

Note that health benefit plans offered by HICs are required to provide mental health parity for drug coverage,[13] but it is unclear whether or not they are required to provide mental health parity for nonprescription drug services. Under current law, if a HIC health benefit plan offers prescription drug coverage, then such coverage must include treatment for biologically based mental illness and such coverage must have parity with standard drug coverage. Other than the elimination of the qualifier that the mental illness be biologically based, this requirement is unchanged under the bill.

With regard to nonprescription services, it is unclear whether or not mental health parity is required for HICs. Under current law, the definition of "basic health care services" includes treatment for mental health conditions. It would appear that this inclusion in the definition of "basic health care services" has generally been interpreted as being a mental health parity requirement, but there does not appear to be any explicit requirement that a HIC offer all basic health care services on the same terms and conditions.

[10] 42 U.S.C. 300gg-6(a), 42 U.S.C. 18022(b)(1)(e), and 42 U.S.C. 18031(d)(4).

[11] 45 C.F.R. 147.150(a); see also Federal Register Vol. 78, No. 37, footnote 64.

[12] R.C. 1751.01(A) and (B).

[13] R.C. 1751.01(B)(2).

MHPAEA compliance

The bill requires each health benefit plan offered in Ohio that is subject to the MHPAEA to meet the requirements of that act. Health benefit plans that are not subject to state regulation are exempt from the bill's requirements.[14]

MHPAEA application

As stated above, the MHPAEA does not require a health benefit plan to offer coverage for mental health and addiction services. It merely requires parity between standard medical benefits and mental health benefits *if* mental health benefits are offered under a plan. The following types of plans that offer mental health and addiction services coverage are *exempt* from the MHPAEA:

- Plans that cover 50 or fewer employees;
- Self-funded plans that cover more than 50 employees and the employer requests to opt out of MHPAEA requirements;
- Large-group plans that incur at least 1% cost increase in a year since complying with MHPAEA.[15]

The only plans that *are* subject to MHPAEA are large group plans that do not incur significant costs and large self-funded plans that do not apply to opt out.

MHPAEA summary

In summary, the MHPAEA requires that, if a health benefit plan offers mental health and addiction services, then, for that plan, there must be parity between those benefits and the medical and surgical benefits offered by the plan in the following areas:

- Annual and lifetime dollar limits;
- Financial requirements;
- Quantitative treatment limitations;
- Nonquantitative treatment limitations.

Quantitative limitations are those benefits that have discreet numerical limits. For example, limiting the number of specialist visits covered under a plan would be a quantitative limitation. Nonquantitative limitations are those benefit limitations that do *not* have a discreet numerical limit. Examples of these would be things like a drug formulary, a determination of which provider types are allowed to be in-network, and step-therapy requirements.[16]

[14] R.C. 3902.51(A)(1).

[15] 29 U.S.C. 1185a(c).

[16] R.C. 3902.50(N) and 29 U.S.C. 1185a(a).

Specific parity requirements

The bill specifies that any designation by a health benefit plan of a disorder as being or not being a substance abuse disorder must be consistent with generally recognized independent standards of current practice.[17] "Generally recognized independent standards of current practice" includes the most current standards set out in or established by the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, the American Society of Addiction Medicine, and state guidelines.[18]

The bill prohibits separate nonquantitative treatment limitations that apply to mental health and substance use disorder benefits, but not to medical and surgical benefits within any classification of benefits.[19]

Report made by health plan issuers

The bill requires health plan issuers subject to the MHPAEA to submit an annual report to the Superintendent of Insurance. The report must contain all of the following:

- A description of the process used to develop or select the medical and clinical necessity criteria, including any criteria established by the American Society of Addiction Medicine, for mental health benefits, substance use disorder benefits, and medical and surgical benefits;
- Identification of all nonquantitative treatment limitations that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits;
- The results of an analysis demonstrating whether, as written and in operation:
  - The processes, strategies, evidentiary standards, and other factors used in applying medical and clinical necessity criteria to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied not more stringently than, those used in applying medical and clinical necessity criteria to medical and surgical benefits within the corresponding classification of benefits;
  - The processes, strategies, evidentiary standards, and other factors used in applying nonquantitative treatment limitations to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied not more stringently than, those used in applying nonquantitative treatment limitations to medical and surgical benefits within the corresponding classification of benefits.

  At a minimum, the results must do all of the following:

[17] R.C. 3902.51(A)(2).

[18] R.C. 3902.50(D).

[19] R.C. 3902.51(A)(3).

- Identify all factors used to determine whether each nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;
- Identify and define the specific evidentiary standards used to determine the factors used to determine nonquantitative treatment limitations and any evidence relied upon in applying each nonquantitative treatment limitation;
- Provide all analyses and results of all analyses that were performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, as written, for mental health and substance use disorder benefits are comparable to, and applied not more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, as written, for medical and surgical benefits;
- Provide all analyses and results of all analyses that were performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and applied not more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;
- Disclose the specific findings and conclusions reached by the health plan issuer regarding compliance with this provision and the MHPAEA.[20]

Prescription drug requirements

The bill imposes the following requirements for any prescription medication prescribed for the treatment of a substance use disorder:

- Except as otherwise provided in the Health Insuring Corporation or Sickness and Accident Insurer Law pertaining to coverage of opioids, the health benefit plan must not impose any prior authorization requirements on any such prescription medication;
- Health benefit plans are prohibited from imposing any sort of step therapy requirement for such a prescription medication;
- The health benefit plan must place all such prescription medications on the lowest tier of the plan's drug formulary;
- The health benefit plan is not to exclude coverage for any such prescription medication or for any associated counseling or wraparound services on the grounds that such medications and services were court ordered.[21]

[20] R.C. 3902.51(B).

[21] R.C. 3902.51(C).

The bill specifies that these requirements are not subject to the law requiring that health benefit mandates are not enforceable unless they can be equally applied to plans that are offered by a state or political subdivision and plans that are subject to ERISA.[22]

Noncompliance

If a person is affected by a health plan issuer's noncompliance with the requirements of the bill or with the MHPAEA, then that person, or a health care provider on the covered person's behalf, may file a complaint with the Consumer Services Division within the Department of Insurance.[23] Medicaid enrollees may file a complaint through a Medicaid managed care organization's grievance process.[24]

Superintendent of Insurance

The bill requires the Superintendent of Insurance to implement and enforce the applicable provisions of the MHPAEA and the reporting and prescription drug requirements described above, including all of the following:

- Proactively ensuring compliance by health plan issuers;
- Evaluating all consumer or provider complaints regarding mental health and substance use disorder benefits for possible parity violations;
- Performing parity compliance market conduct examinations of health plan issuers, particularly market conduct examinations that focus on nonquantitative treatment limitations;
- Requiring health plan issuers to submit the analyses described above under "**Report made by health plan issuers**";
- Adopting rules as needed to do both of the following:
  - Effectuate any MHPAEA provisions that relate to the business of insurance;
  - Enforce, monitor compliance with, and ensure continued compliance with the reporting and prescription requirements listed above.[25]

Annual report

Under the bill, the Superintendent is required to issue an annual report related to health plan issuers and the MHPAEA. The report must use readily understandable language and be made available to the public, including by posting it on the Department's website. The report must cover all of the following:

[22] R.C. 3902.51(D) and R.C. 3901.71, not in the bill.

[23] R.C. 3902.51(E).

[24] R.C. 5167.47(C).

[25] R.C. 3901.57(B).

- The methodology the Superintendent uses to check for compliance with the MHPAEA and the reporting and prescription drug requirements described above;
- Market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations;
- Any educational or corrective actions the Superintendent has taken to ensure health plan issuer compliance with the MHPAEA and the reporting and prescription drug requirements described above;[26]

Note, under current law, unchanged by the bill, the Superintendent is already required to work with the Department of Mental Health and Addiction Services to provide an annual report on mental health parity.[27]

Medicaid

Biennial report

Under the bill, the Medicaid Director must issue a biennial report about Medicaid managed care organizations and parity in mental health and substance use disorder benefits provided to Medicaid enrollees. The report must use readily understandable language and be made available to the public, including by posting it on the Department's website. The report must do all of the following:

- Cover the Director's methodology to check for compliance with mental health parity requirements, including MHPAEA compliance;
- Identify market conduct examinations conducted or completed during the preceding two years regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations;
- Detail any educational or corrective actions the Director has taken to ensure Medicaid managed care organization mental health parity requirements, including MHPAEA compliance.[28]

MHPAEA compliance

The bill also requires the Medicaid Director to do both of the following:

[26] R.C. 3901.57(C).

[27] R.C. 3901.90, not in the bill.

[28] R.C. 5162.137 and 5167.47(B).

- Implement and enforce MHPAEA compliance with respect to Medicaid managed care organizations;[29]
- Enforce, monitor compliance with, and ensure continued compliance with other related requirements.[30]

The bill authorizes the Medicaid Director to adopt rules as needed to carry out the bill's requirements.[31]

Definitions

The bill relocates several definitions from R.C. 3922.01 to R.C. 3902.50 for the sake of clarity. These relocated terms are not altered in any way.

HISTORY

Action	Date
Introduced	12-09-19

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[29] R.C. 5167.47(A).

[30] R.C. 5167.47(B) and (D).

[31] R.C. 5167.47(E).