

## Ohio Department of Insurance Mental Health Parity - Frequently Asked Questions

The main provisions of the Ohio Mental Health Parity law can be found in sections 1751.01, 3923.28, 3923.281 and 3923.282 of the [Ohio Revised Code](#).

**Q: What benefits must be provided under the Mental Health Parity law?** A: Benefits must be provided for the diagnosis and treatment of biologically based mental illness ("BBMI") on the same terms and conditions as, and no less extensive than, those provided for the treatment and diagnosis of all other physical diseases and disorders. A Health Insuring Corporation ("HIC") that offers coverage for any other basic health care service must offer coverage for diagnostic and treatment services for biologically based mental illnesses.

**Q: When must these benefits be provided?** A: Insurance policies and plans of health coverage that are established, delivered, issued for delivery, modified or renewed in Ohio on or after October 1, 2007, must include these benefits.

**Q: Which types of insurance policies must include coverage for BBMI?** A: The Ohio Mental Health Parity law, as amended by the 2007 biennium Budget Bill, requires that every policy of sickness and accident insurance, including group, individual, and blanket insurance, but excluding the types of policies listed in the answer to Question 6 below, must provide the required BBMI benefits. The law also applies to both individual and group evidences of coverage offered by HICs that provide coverage for "basic health care services."

**Q: Does coverage extend to benefits offered by self-insured employers?** A: Yes. The Ohio Mental Health Parity law applies to plans of health coverage offered by private or public self-insured employers, unless federal law supersedes, preempts, prohibits, or otherwise precludes its application. For example, public employee pension plans would be subject to the parity requirements, but private, single employer self-insured plans would not be subject to the requirements.

**Q: Will insurance policies provided through non-employer association groups, unions or trusts be required to include BBMI coverage?** A: Yes. The law applies to non-employer based insurance plans, such as those provided through associations, unions or trusts.

**Q: What types of insurance products are not covered under this new law?** A: The Mental Health Parity law does not apply to Medicaid, Medicare, hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited duration policies of not longer than six months (short-term), supplemental benefit or other policies that provide coverage for specific diseases or accidents only, worker's compensation or any federal health care program.

**Q: Does Ohio's Mental Health Parity law apply to benefits for substance abuse or chemical dependency treatment?** A: No. Substance abuse and chemical dependency are not included in the definition of BBMI.

**Q: Can mental health benefits continue to be "carved out" from other medical benefits and contracted for separately by employers or insurers?** A: Yes. Benefits for mental health treatment can continue to be provided through separate contracts; however, those contractual arrangements may need to be adjusted to comply with the Mental Health Parity law's requirement that the insurance policy include benefits for BBMI. Benefits provided for BBMI outside of an insurance policy must comply with the law's requirement that they be subject to the same terms and conditions as benefits provided for all other physical diseases and disorders.

**Q: Does Ohio's Mental Health Parity law prohibit deductibles, co-payments and/or other cost-sharing elements being applied to BBMI services?** A: No. Deductibles and co-payments are not prohibited as long as such cost-sharing limitations are equally applied to services for the treatment of physical illness and disorders. For example, the inpatient deductible for a hospital stay to treat BBMI must be the same as the inpatient deductible to treat physical illnesses. If a plan requires a higher co-payment to use a specialist, then a person

seeking treatment from a specialist for BBMI may be required to pay the higher specialist co-payment.

**Q: Can a policy or plan of health coverage require that services for BBMI be pre-authorized?** A: Yes. A plan may require pre-authorization for particular services for the treatment of BBMI only if pre-authorization is required for the same services when provided to treat physical illness. For example, a carrier that requires pre-authorization for all hospital admissions may require pre-authorization for a hospital admission for BBMI. Similarly, pre-authorization may be required specifically for outpatient treatment of BBMI only if it is required for outpatient treatment for all other physical diseases and disorders, or for all other outpatient basic health care services for HICs.

**Q: Is there a requirement to provide coverage for prescription drugs associated with the treatment of BBMI?** A: No. Prescription drug coverage for the treatment of BBMI is not a mandated benefit. However, if the health plan provides prescription drug coverage, then the coverage shall include prescription drugs to treat BBMI.

**Q: If every group sickness and accident insurance policy is now required to provide coverage for BBMI, does this mean that the \$550 outpatient benefit mandate for mental or emotional disorders is also triggered?** A: Yes. Pursuant to [Section 3923.28 of the Revised Code](#), every group policy that provides coverage for mental or emotional disorders shall provide at least \$550 of outpatient benefits for mental or emotional disorders for each eligible person. It is the Department's interpretation that coverage for BBMI is coverage for a mental disorder, therefore in addition to coverage for BBMI, every group policy of sickness and accident insurance must also comply with the requirement to provide at least \$550 of outpatient benefits for mental or emotional disorders. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition comments upon the fact that there is not an agreed upon definition of mental disorders and points out that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. However, it is the Department's view that the more persuasive argument is that coverage for BBMI can not be considered as coverage solely

for a physical disorder and therefore should be considered as coverage for a mental disorder.

Please note that [Section 3923.28\(F\) of the Revised Code](#) provides that the \$550 of outpatient benefits for mental or emotional disorders required under this section may not be reduced by the cost of benefits provided for BBMI.

Please also see [Section 3923.30 of the Revised Code](#) with regard to public and private plans of health care benefits.

**Q: Will the Mental Health Parity law affect the definition of “eligible provider(s)” within the terms of health insurance coverage?** A: Yes. Prior to the enactment of this law, only licensed physicians and psychologists were required to be reimbursed for providing covered mental health services. Under the new law, the definition of eligible providers includes clinical nurse specialists whose nursing specialty is mental health, professional clinical counselors, professional counselors and independent social workers. Such practitioners must be included as eligible providers within the terms of health insurance policies, certificates and plans of health coverage.

**Q: Are form filings required by health insurance companies and HICs in order to comply with the Mental Health Parity law?** A: Yes. To the extent required to bring existing policies or contracts into compliance with these new requirements, insurance companies and HICs must submit revised policies, contracts, certificates, evidences of coverage forms and other related filings or submit riders/endorsements.

**Q: Are there any special requirements for filings?** A: Yes. When filing riders/endorsements/amendments to existing forms, we request that companies identify all affected policies, certificates, amendments, riders and/or forms that may have previously been approved and supply the Ohio Department of Insurance File Number and approval date(s) for each.

**Q: How does the Mental Health Parity law affect Ohio Health Care Basic and Standard plans?** A: The Board of the Ohio Health Reinsurance Program has revised the benefit designs

for the basic and standard HIC and indemnity plans to include coverage for BBMI.

**Q: Must the employer absorb the additional cost of this coverage, if any?** A: The bill does not require an employer to assume any additional cost to achieve parity. Therefore, some (or all) of the increased costs could be passed on to the employee.

**Q: If there are changes to the federal mental health parity law, will Ohio's mental health benefits change?** A: Maybe. It depends upon the extent of the changes made in federal law and to what degree the changes impact Ohio's laws.

**Q: How does the "opt out" provision for insurers work?** A: In order for an insurance company to "opt out" of providing benefits for BBMI, the company must request and qualify for an exemption as determined by the Department of Insurance.

**Q: If a health insurance carrier or HIC intends to request an exemption from providing BBMI benefits, can they provide evidence based upon actuarial studies of previously incurred historical claims expenses and/or industry-wide claims data?** A: No. The law provides that in order to request an exemption, the documentation must be based upon actual "incurred claims for diagnostic and treatment services for BBMI for a period of at least six months" after the mandate has been in effect.

**Q: Is there any difference between a health insurance carrier and a HIC in the type of claims data that must be presented in order to request an exemption?** A: Yes. For Title 39 insurance companies, the documentation must show that the claims incurred as a result of providing the required BBMI coverage "independently caused the insurer's costs for claims and administrative expenses for coverage of all other physical diseases and disorders to increase by more than one per cent per year" (emphasis added). HICs must provide the same actuarial certification; however, the documentation must demonstrate that the BBMI claims expenses caused the HIC's costs for claims and administrative expenses for the coverage of basic health care

services (which includes BBMI) to increase by more than 1% per year.

**Q: Who should be contacted for further information regarding coverage under this new law?** A: For questions regarding specific insurance coverage, insureds/enrollees should contact their respective insurance companies or HICs. Employees covered under self-funded plans should contact their employers or plan administrators. For questions regarding general health insurance and for specific questions regarding coverage under the BBMI law, Ohio residents may contact the Consumer Services Division of the Ohio Department of Insurance at 1-800-686-1526. Companies with questions regarding coverage under the law may contact the Life and Health Division of the Ohio Department of Insurance at (614) 644-2644.