

Coverage for Mental Health Conditions, Drug and Alcoholism Use Disorders in Ohio

Frequently Asked Questions

Q: How do I find out whether I have coverage for mental health conditions, or drug or alcohol use disorders?

A: The best place to find out whether you have coverage for mental health conditions, or drug or alcohol use disorders is to read your certificate of coverage (referred to as a “summary,” “summary plan description,” or a “cert book”). This is generally a booklet that your insurer or employer provides to you when you enroll in your health benefit plan. The summary describes and explains the terms and conditions of your health benefit coverage. You may receive a hard copy or be able to access this document online.

As you review the summary, you will find a section describing any benefits under your plan for mental health conditions and/or drug or alcohol use disorders. The plan will provide definitions that will help you determine what is covered. Be sure to also check the exclusions section to determine if the treatment you are seeking is specifically excluded. You can also contact your plan administrator, your employer’s human resources department or your health insurer with questions about your coverage.

Q: The new federal law, the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, requires health benefit plans to cover mental health conditions and substance use disorders, including alcoholism, the same as any other illness. Does the law apply to all health care coverage?

A: The following entities are subject to the Act:

- (1) Large Employer Group Plans: Large employers that provide group health benefit plans which include some form of coverage for mental health conditions or substance use disorders must provide benefits for mental health conditions and substance use disorders under the same terms and conditions as the plan provides for medical and surgical services. Large employers are defined as an employer having 51+ employees during a year.
- (2) Health Insurance Companies: Insurance companies providing major medical and surgical health insurance policies in connection with a large employer group health benefit plan must include benefits in their policies for the diagnosis and treatment of mental health conditions and substance use disorders on the same terms and conditions as the policy provides for the diagnosis and treatment of medical and surgical conditions and disorders.

- (3) State and Local Government Plans: State and other non-federal government health benefit plans that provide self-funded group health plan coverage (coverage that is not provided through an insurer) may elect to opt-out from the requirements of the Act.

Q: Will Ohio small employers have to provide benefits for mental health conditions and substance use disorders?

A: The federal law, the Domenici-Wellstone Act, specifically exempts small employers from its application. A small employer is defined as one having 50 or fewer employees in a year. Under Ohio law however, small employers are required to include benefits for biologically-based mental illness as well as limited benefits for outpatient mental or emotional disorders and alcoholism.

Q: What does “parity” mean?

A: The term “parity” means that mental health conditions and substance use disorders must be treated by the plan in the same manner as the plan treats benefits for medical and surgical conditions and disorders. In other words, all of the financial requirements such as co-pays, deductibles and out of pocket maximum limitations applied to mental health and substance use benefits may be no more restrictive than for physical health benefits. Similarly, any treatment limitations such as number of permitted visits or restrictions on treatment settings applied to mental health and substance use benefits may be no more restrictive than for physical health benefits.

Q: How does the Wellstone-Domenici Mental Health Parity and Addiction Equity Act define “mental health benefits” or “substance use disorder benefits”?

A: The Act provides that the terms “mental health benefits” and “substance use disorder benefits” will be as “defined under the terms of the plan and in accordance with applicable federal and state law.” Neither federal nor Ohio law provide a specific definition of what mental health or substance use disorder benefits must be covered in a health benefit plan or insurance contract. That is why it is best to refer to your plan’s summary description to find out what is covered.

Q: Will the federal government be issuing additional guidance on the Act?

A: Yes. The three federal agencies charged with enforcement of the Act have indicated that additional guidance will be forthcoming early in 2010.

Q: Does the new federal mental health parity law preempt the Ohio Mental Health Parity Act of 2007?

A: No. The federal law provisions can be thought of as sitting on top of the state law provisions. To the extent the federal law applies and requires greater benefits it should be

followed. However, state law provisions continue in effect. The interaction between the two laws is explored further in the questions below.

Q: What mental health coverage does Ohio law require health benefit plans to offer?

A: Ohio law requires health benefit plans, including individual, small group, fully-insured and private or public self-funded plans (to the extent not pre-empted by federal law) to cover the diagnosis and treatment of biologically-based mental illnesses, as defined in state law. It also requires plans to provide a limited \$550 per year benefit for outpatient mental or emotional disorders. Notably, however, this Ohio law does not generally apply to self-insured private employer plans governed by ERISA.

Q: Does Ohio law require health benefit plans to provide coverage for drug use disorders?

A: No, there are no state statutes that require health benefit plans to provide coverage for drug use disorders.

Q: Does Ohio law require health benefit plans to provide coverage for alcohol use disorders?

A: In some cases. Individual sickness and accident insurance policies do not have to include coverage for alcohol use disorders. Group sickness and accident policies do have to provide a minimum benefit of \$550. Self-funded employer plans not subject to ERISA must also provide a \$550 benefit. Insurance coverage sold to groups with more than 50 employees must provide alcohol use disorder benefits that are in parity with medical benefits.

Q: Will insurance policies provided through association groups, unions or trusts be required to include coverage for biologically-based mental illnesses under Ohio law?

A: Yes. The law requires all health insurance companies to include these benefits in its policies—it does not matter to whom the policy is issued.

Q: Will insurance policies provided through association groups, unions or trusts be required to include coverage for mental health conditions and substance use disorders under the Wellstone-Domenici Act?

A: Unions will be subject to the Act. Associations and trusts that provide coverage for any employment-related plans will be subject to the Act if the plans cover large employer groups.

Q: What types of health benefit plans are not covered under either the federal or state mental health parity laws?

A: Mental health and substance use disorder parity laws do 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, workers' compensation or any federal health care program.

Q: Can benefits for biologically based mental illness or mental health conditions be “carved out” from other medical and surgical benefits in the policy 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 state and federal Mental Health Parity laws.

Q: Do the state and federal parity laws prohibit deductibles, co-payments and/or other cost-sharing elements being applied to mental health or substance use disorders?

A: No. Deductibles and co-payments are not prohibited as long as such cost-sharing limitations are no more restrictive than when applied to services for the treatment of physical illness and disorders. If a plan requires a higher co-payment to use a specialist, then a person seeking treatment from a specialist for a mental health condition may be required to pay the higher specialist co-payment.

Q. Does the federal parity law prohibit separate deductibles for mental health or substance use disorder benefits?

A: Yes.

Q: Can a policy or plan of health coverage require that services for mental health conditions be pre-authorized?

A: Yes. A plan may require pre-authorization for particular services for the treatment of mental health conditions if the pre-authorization requirement is no more restrictive than the predominant pre-authorization limitations applied to substantially all services to treat physical illness.

Q: If every group sickness and accident insurance policy in Ohio is required to provide coverage for biologically-based mental illness, 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 some form of coverage for mental or emotional disorders shall provide at least \$550 of outpatient benefits for mental or emotional disorders for each eligible person, even if the mental or emotional disorder is not defined as a biologically-based mental illness.

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 biologically-based mental illnesses.

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

Q: Under Ohio’s Mental Health Parity law, is coverage limited to services performed by physicians and psychologists?

A: No. Under the new law, eligible providers include 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 Ohio’s Mental Health Parity law and the Wellstone-Domenici Act?

A: Yes. Prior to selling coverage in Ohio, insurers must file policy forms with the Department of Insurance that include the mental health benefits required by law..

Q: Are there any special requirements for insurers’ filings to comply with Ohio’s Mental Health Parity law and the Wellstone-Domenici Mental Health Parity and Addiction Equity Act?

A: Yes. When filing riders/endorsements/amendments to existing forms, companies must 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: If providing parity for these benefits increases the cost of my coverage, who will pay the additional costs?

A: There are no provisions in the laws governing who is to pay for any costs related to the parity mandates. Employers that self-fund their health benefit plans will pay any increased costs; however, most employers require their employees to share the cost of insurance. In those instances, the employers may choose to pass on any increased costs to employees. Insurance companies routinely adjust premiums to cover any increases in their cost of providing benefits.

Q: Which statutes require coverage for biologically-based mental illnesses?

A: If you have coverage through a health insuring corporation (a HIC or an “HMO”), the governing statute is section 1751.01 of the Revised Code. For individual and group sickness

and accident insurance policies (traditional major medical and surgical insurance), the governing statute is section 3923.281 of the Revised Code. If you are covered by a public or private self-funded, employer health benefit plan, the governing statute is section 3923.282 of the Revised Code.

Q: Who should be contacted for further information regarding coverage under Ohio's Mental Health Parity 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 biologically-based mental illness law, Ohio residents and employers may contact the Consumer Services Division of the Ohio Department of Insurance at 1-800-686-1526. Insurance companies with questions may contact the Product Regulation Division of the Ohio Department of Insurance at (614) 644-2644.

Q: Who can be contacted for further information regarding the federal mental health and substance use disorder law?

A: For questions regarding specific insurance coverage, you should contact your plan administrator, employer, or your insurance carrier or HIC, depending on what type of coverage you have. You may also contact the Department of Labor at 866-444-3272, which has jurisdiction over self-funded employers.
