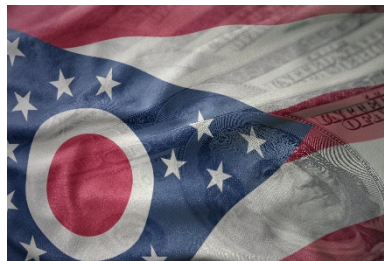


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Pursuit of Parity: Where Ohio stands on insurance coverage of mental illness and substance use disorders

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KEY TAKEAWAYS

- Despite mental health parity laws that were passed more than a decade ago, consumers have very little awareness of their insurance coverage rights for mental health and substance use disorder treatment.
- Ohio patients in need of behavioral health services are up to five times more likely to have to go out of network for treatment than patients in need of medical or surgical care.
- Ohio's insurance laws are in conflict with federal parity laws that prohibit insurers from imposing limitations on mental health and substance use disorder services that are more restrictive than for physical health services.

Introduction

Achieving parity in insurance coverage of behavioral health services is an aspiration that has evaded policymakers and consumer advocates for now more than half a century.¹ At its core, “parity” in behavioral health policy, means that insurance plans that cover mental health and substance use disorder (SUD) services make those services equally accessible and no more cost prohibitive than medical and surgical services of comparable scope. Congress and state legislatures have passed numerous pieces of legislation aiming to ensure parity, but these laws have proved notoriously difficult to enforce.

In 1996, President Bill Clinton signed the Mental Health Parity Act (MHPA) into law, prohibiting large group health insurance plans from establishing annual and lifetime dollar limits on mental health coverage that are more restrictive than such limits for medical coverage.² Five years later, then Senator Mike DeWine

¹ U.S. Department of Health and Human Services. 2018. Parity Policy and Implementation. <https://www.hhs.gov/about/agencies/advisory-committees/mental-health-parity/task-force/resources/index.html>

² 104th Congress. H.R. 3666. Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997. <https://www.congress.gov/bill/104th-congress/house-bill/3666>

was one of 66 U.S. Senators to cosponsor the Mental Health Equitable Treatment Act of 2001.³ This bipartisan legislation was meant to build on MHPA by prohibiting large group plans from imposing any limitations or financial requirements for mental health benefits that are more restrictive than such requirements for medical and surgical benefits. The bill was one of several iterations of parity legislation from both chambers of Congress that never reached the president's desk during the early and mid-2000s. Amid the 2008 financial crisis, Representative Patrick Kennedy (a leading mental health advocate in Congress) found a vehicle to finally pass the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) by packaging it with the Emergency Economic Stabilization Act of 2008.⁴

Ohio passed its own parity law in 2006, however, Ohio's law is narrower in scope than MHPAEA and the Ohio Revised Code (ORC) has not been updated to align state statute with federal parity law.⁵ Meanwhile, recent empirical research and abundant anecdotal evidence from consumers and health care providers have indicated that true parity in commercial insurance has not yet been achieved in Ohio nor in the rest of the country. Given Governor DeWine's previous support of parity legislation in Congress, it is perhaps unsurprising that his young administration has identified strengthening enforcement of MHPAEA as a key priority in the governor's behavioral health policy agenda. This report will offer an explanation of what is required by state and federal parity laws, explore existing evidence of Ohio's shortcomings in parity enforcement and identify policy recommendations circulating among parity advocacy groups and the new administration.

Overview of state and federal parity law

Ohio's parity law

Ohio law mandates that individual, group and public employee health insurance plans cover benefits for mental health care, and that group and public employee plans cover benefits for alcoholism treatment.⁶ Senate Bill 116 of the 126th General Assembly, signed into law by Governor Bob Taft in 2006, requires individual, group and public employee plans to cover the diagnosis and treatment of "biologically-based" mental illnesses at parity with physical health benefits.⁷ Under the law, biologically-based mental illnesses are limited to schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder and panic disorder, as defined by the American Psychiatric Association. The law requires that every applicable plan provide benefits for these conditions that are "no less extensive than those provided under the policy or plan for the diagnosis and treatment of all other physical diseases and disorders."⁸ Specifically, this equal benefits mandate applies to coverage of inpatient hospital services, outpatient services and medication, as well as maximum lifetime benefits, copayments and deductibles.

³ 107th Congress. S. 543. Mental Health Equitable Treatment Act of 2001. <https://www.congress.gov/bill/107th-congress/senate-bill/543>

⁴ 110th Congress. H.R. 1424. Emergency Economic Stabilization Act of 2008. <https://www.congress.gov/bill/110th-congress/house-bill/1424>

⁵ 126th General Assembly. S.B. 116. http://archives.legislature.state.oh.us/bills.cfm?ID=126_SB_116

⁶ Ohio Revised Code, Sec. 3923.28.

⁷ 126th General Assembly. S.B. 116. http://archives.legislature.state.oh.us/bills.cfm?ID=126_SB_116

⁸ Legislative Services Commission. Bill analysis of Am. Sub. S.B. 116 as passed by the 126th General Assembly. http://archives.legislature.state.oh.us/analysis.cfm?ID=126_SB_116&ACT=As%20Enrolled&hf=analyses126/06-sb116-126.htm

There are several ways in which Ohio's parity law is limited in scope. An obvious limitation is that it only applies to coverage for a relatively short list of mental illnesses and does not include substance use disorders. Additionally, the law expressly permits insurers to separately negotiate reimbursement rates with mental health providers and to employ utilization management techniques like prior authorization to limit the rendering of mental health services. Both of these practices can make services less accessible and more expensive for consumers, and were limited under federal parity law. Finally, insurers and employers do not have to continue coverage for biologically-based mental illnesses under Ohio's law if they can prove that claims for those services caused a one percent annual increase in total claims or premium rates.

Federal Parity Law

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) preserved and added to the earlier MHPA protections for mental health (MH) benefits covered by large group health plans, and extended those protections to SUD benefits.⁹ While the law does not directly require insurers to cover MH/SUD benefits, it establishes parity requirements for plans that choose to include MH/SUD coverage in their benefit packages. Under MHPAEA protections, a large group health plan with MH/SUD coverage cannot:

- Impose annual or lifetime dollar limits on MH/SUD benefits that are more restrictive than such limits imposed on medical/surgical benefits.
- Impose financial requirements (e.g., deductibles and copayments) and treatment limitations (e.g., limits on visits or days of coverage) for MH/SUD benefits that are more restrictive than financial requirements or treatment limitations for the same plan's medical and surgical benefits.
- Impose any separate cost sharing requirements or treatment limitations that only apply to MH/SUD benefits.
- Deny out-of-network MH/SUD services if the plan provides for out-of-network medical/surgical benefits.

Although MHPAEA originally only applied to large group health plans (more than 50 employees), the Patient Protection and Affordable Care Act of 2010 (ACA) extended parity requirements to non-grandfathered individual and small group plans. Additionally, states that expanded Medicaid to cover low-income childless adults under the ACA are required to cover MH/SUD benefits at parity to medical/surgical benefits for the Medicaid expansion population.

Regulatory Environment of Parity

Federal Rules

The U.S. Department of Health and Human Services issued final rules for MHPAEA in November of 2013.¹⁰ These regulations specify benefit classifications to which the parity law applies and establish requirements for how insurance plans can set treatment limitations.

⁹ The Center for Consumer Information & Insurance Oversight. The Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

¹⁰ Federal Register, Vol. 78, No. 219. (Nov. 13, 2013). Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. <https://www.govinfo.gov/content/pkg/FR-2013-11-13/pdf/2013-27086.pdf>

Benefit Classifications. The MHPAEA rules stipulate that parity requirements apply across six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs. Plans are permitted to establish sub-classifications for office visits, as well as to distinguish between multiple tiers of in-network providers. If a plan covers medical/surgical benefits in any of these classifications, it must also cover MH/SUD benefits within that same classification. Further, the rules require that plans combine both medical/surgical benefits and MH/SUD benefits within a given classification when establishing financial requirements, such as deductibles or out-of-pocket maximums, for plan members. In other words, financial requirements imposed on the consumer must reflect a benefit package that is cumulative of both medical/surgical and MH/SUD benefits, rather than establishing separate financial requirements for MH/SUD benefits.

Treatment Limitations. A major barrier to enforcement of parity law is the complexity of the insurance industry and the vast tools at insurers' disposal to limit access to MH/SUD treatment. The MHPAEA rules distinguish between *quantitative* and *nonquantitative* treatment limitations, in an attempt to apply parity requirements to all of the ways an insurer may manage utilization of benefits. Quantitative treatment limitations can be measured numerically, and include but are not limited to visit limits and day limits on benefits, deductibles, copayments and out-of-pocket maximums. Nonquantitative treatment limits are more difficult to measure and include, but are not limited to, requirements around medical management, prior authorization and step therapy, as well as provider reimbursement rates and provider network adequacy. The regulations prohibit a plan from imposing a nonquantitative treatment limit on MH/SUD benefits unless the processes and standards for applying such limits are "comparable to, and applied no more stringently than," such limitations for medical/surgical benefits in the same classification.

Table 1

Utilization Management Techniques Subject to Parity Law	
Quantitative Treatment Limits/Financial Requirements	Nonquantitative Treatment Limits
Visit limits	Medical management standards
Day limits	Formulary design for prescription drugs
Deductibles	Network tier design
Copayments	Provider reimbursement rates
Coinsurance	Prior authorization
Out-of-pocket maximums	Step therapy
	Geographic restrictions

Parity Regulation in Ohio

The Ohio Department of Insurance (ODI) is the primary state agency charged with enforcing state and federal parity law within Ohio's private insurance industry. ODI reviews all proposed health insurance products to ensure compliance with parity laws before those products can go to the market.¹¹ ODI also

¹¹ Ohio Departments of Insurance and Mental Health and Addiction Services. 2018. Ohio Mental Health Parity Report. <https://insurance.ohio.gov/Legal/Reports/Documents/Ohio%20Mental%20Health%20Parity%20Report%20-%202018.pdf>

has a Consumer Services division where consumers can file complaints against their insurance plan or ask questions about their coverage rights. Consumer services representatives assist consumers using a toll-free hotline, educational materials, counseling and community outreach. The department also monitors insurers' compliance with parity law through its Market Conduct division, which examines business practices such as marketing and claims handling, and gathers industry information to identify broader trends around parity compliance.

Ohio law requires ODI and the Department of Mental Health and Addiction Services (ODMHAS) to develop consumer and payer education around parity, operate the consumer hotline, and submit a report to the governor and General Assembly each year on the departments' parity efforts. According to the most recent ODI and ODMHAS parity report, ODI received only seven consumer complaints specific to mental health or SUD benefits in the 2017 calendar year, out of a total of more than 2,500 complaints about health or accident insurance.¹² This near absence of consumer complaints is likely more indicative of a lack of consumer awareness about their coverage rights, rather than signaling full achievement of parity in the insurance industry. To improve consumer outreach efforts, ODI worked with ODMHAS and other stakeholders to create an online Mental Health Parity Toolkit to help consumers understand their coverage rights. ODI has requested a budget increase of \$1 million in both fiscal years 2020 and 2021 to continue escalating parity education and enforcement.¹³

Measuring disparity in access to MH/SUD benefits

Consumer experience

Although more than a decade has passed since MHPAEA was passed into federal law, consumers continue to experience disparities in access to behavioral health services. One of the groups leading the efforts to highlight this disparity is Parity at 10, an advocacy campaign working to raise awareness and improve enforcement of parity law in Ohio and across the country. Earlier this year, Parity at 10 published the results of an extensive survey of consumers and healthcare providers in Ohio and four other states.¹⁴ The survey found that more than a third of consumers (36 percent) reported that their insurance plan had denied, delayed or limited their coverage for a MH/SUD service. Of those consumers, only 33 percent reported that they appealed the service denial with their insurance company. Only eight percent said they filed a complaint with a government agency. The survey results also showed that consumers were significantly more likely to appeal their insurer's denial of a physical health benefit than they were for a MH/SUD benefit. Consumers' hesitancy to report or appeal a denial of MH/SUD service is likely explained by a lack of knowledge about their coverage rights. According to survey results, only 42 percent of consumers knew they had the right to coverage for MH/SUD services that is equal to their coverage for medical/surgical services.

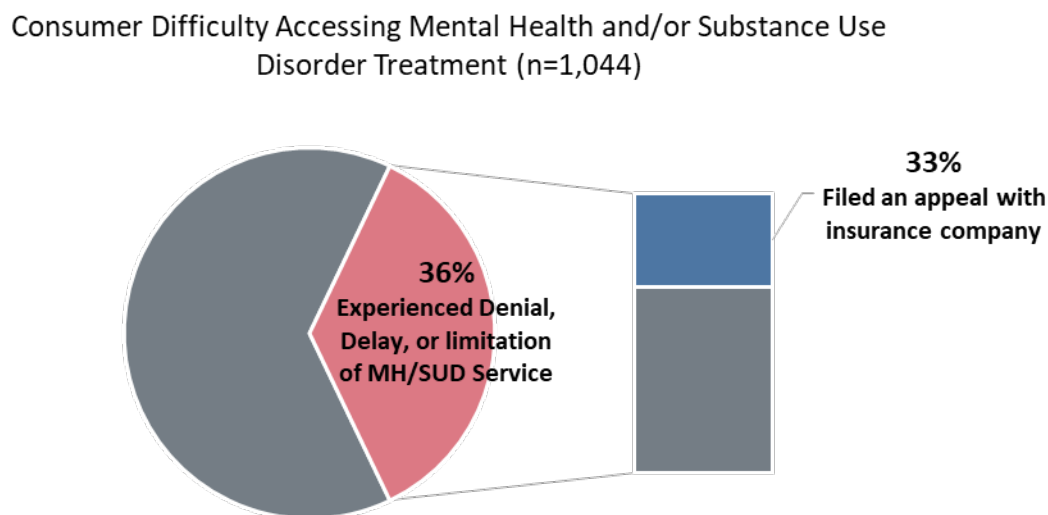
¹² Ohio Departments of Insurance and Mental Health and Addiction Services. 2018. Ohio Mental Health Parity Report.

<https://insurance.ohio.gov/Legal/Reports/Documents/Ohio%20Mental%20Health%20Parity%20Report%20-%202018.pdf>

¹³ Jillian Froment. (2019). Testimony before the House Finance Subcommittee on Health and Human Services on March 28, 2019. <http://www.ohiohouse.gov/committee/finance-subcommittee-on-health-and-human-services>

¹⁴ Parity at 10. 2019. Consumer health insurance knowledge and experience survey: report of findings. http://parityat10.org/wp-content/uploads/2019/03/Consumer-Health-Insurance-Knowledge_ExperienceSurvey-Report-030719.pdf

Figure 1



Source: Parity at 10, Consumer Health Insurance Knowledge and Experience Survey.

Parity at 10's survey of health care providers also indicated significant disparities in MH/SUD benefit access, with 72 percent of providers reporting that their patients face insurance-related barriers to accessing MH/SUD services.¹⁵ However, more than a third of providers (35 percent) said they do not know how to best assist their patients address denials for services. According to stakeholder listening sessions held by the campaign in Ohio, providers are sometimes informed by insurers that they cannot file complaints on behalf of patients, despite Ohio law expressly permitting them to do so.¹⁶

Network Adequacy Barriers

In 2017, the research firm Milliman published a landmark analysis of medical claims records from major insurers for preferred provider organizations (PPOs) covering 42 million individuals across the United States as of 2015.¹⁷ The Milliman report uncovered stark disparities in access to MH/SUD services in terms of out-of-network utilization rates and reimbursement rates paid to providers by insurers. The researchers found that between 2013 and 2015, the proportion of consumers nationwide who received behavioral health care outside of their insurers' provider network was 2.8 to 5.8 times higher than the proportion who receive medical/surgical care out of network, depending on the classification of service. At the same time, insurers paid primary care providers up to 22 percent higher rates than behavioral health providers for office visits of comparable scope. Medical/surgical specialty care providers were paid up to 19 percent

¹⁵ Parity at 10. 2019. Provider Parity Act knowledge and practice survey: report of findings. http://parityat10.org/wp-content/uploads/2019/03/ParityAt10-Report_Provider-Survey-Summary_03719_Final.pdf

¹⁶ Parity at 10. 2018. Landscape review: Ohio.

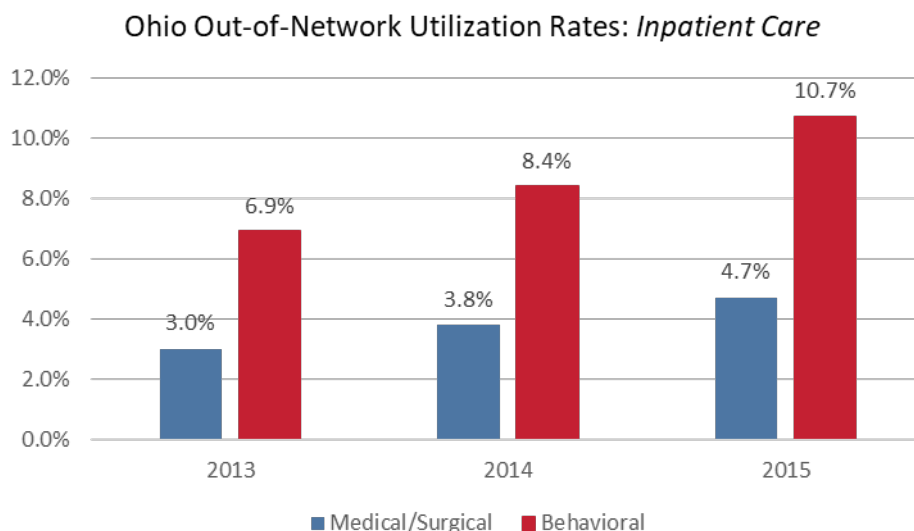
¹⁷ Melek, S.P., Perlman, D., Davenport, S. (2017). Addiction and mental health vs. physical health: analyzing disparities in network use and provider reimbursement rates. *Milliman*. <http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>

higher rates for office visits than behavioral health providers. Lower reimbursement rates are a major factor that can lower network participation among behavioral health providers, leading more consumers to have to receive MH/SUD services out of network—where out-of-pocket costs are typically higher.

Like the rest of the country, Ohio has seen clear disparities in out-of-network care and provider reimbursement for behavioral health benefits. The Milliman Report found that in 2015, Ohioans were between 2.3 and 4.9 times more likely to receive behavioral healthcare out of network than they were for physical health services, depending on the care setting. Also in 2015, primary care providers and specialists were paid 21 percent and 22 percent higher, respectively, than behavioral specialists for office visits of comparable scope.

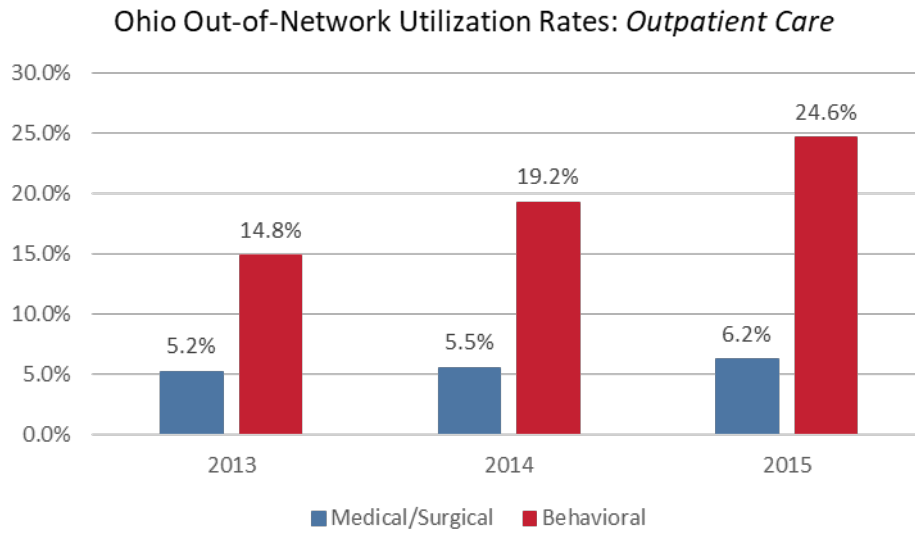
Figures 2, 3 and 4 below highlight Ohio’s rates of behavioral and physical health services provided out of network from 2013 to 2015, according to the claims data presented by Milliman. Figure 5 shows the rates paid by PPO plans to Ohio providers for office visits, relative to Medicare-allowed amounts as a baseline.

Figure 2



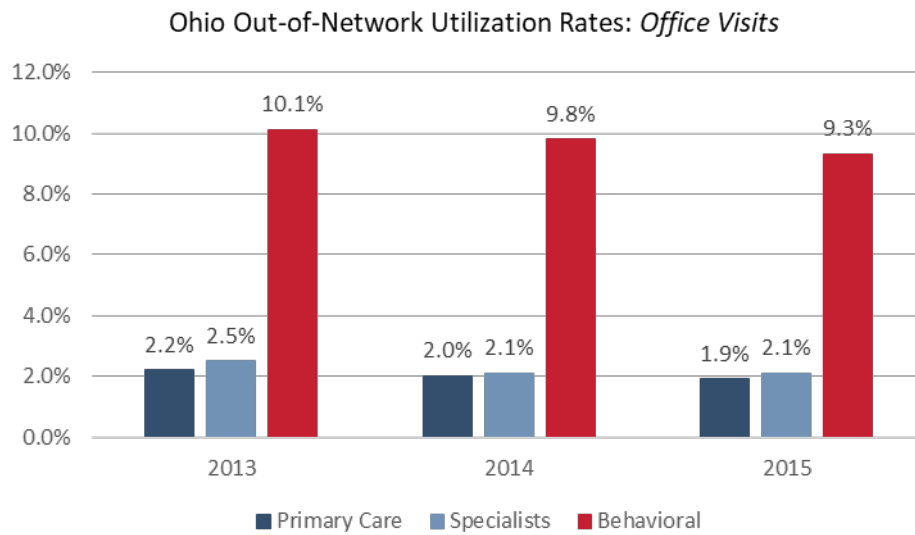
Source: Milliman, 2017.

Figure 3



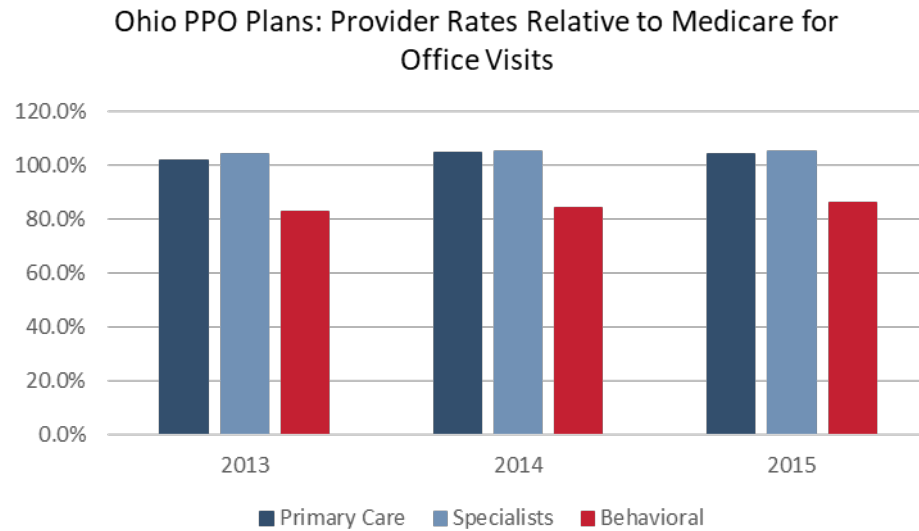
Source: Milliman, 2017.

Figure 4



Source: Milliman, 2017.

Figure 5



Source: Milliman, 2017.

While the Milliman report itself did not identify specific causes for the observed disparities in out-of-network utilization rates and provider reimbursement rates, the authors noted that these findings “may point to underlying issues of noncompliance with MHPAEA.”¹⁸ Network adequacy and provider reimbursement are each important examples of nonquantitative treatment limits that the final MHPAEA regulations sought to address.

Current policy landscape and potential next steps

Parity has been elevated by health and human services advocates as a critical policy solution for addressing Ohio’s ongoing substance use and mental health crisis. Under true parity, emergency treatment, necessary medication, follow-up care and recovery services would be equally accessible under private insurance for a victim of an opioid overdose as they are for a heart attack victim. Recent research from The Ohio State University found that counties with less access to medication-assisted treatment for opioid use disorder often had higher rates of overdose.¹⁹ Further, in the absence of strict regulation of commercial insurers to enforce MH/SUD coverage requirements under parity law, a shift in cost to public services becomes more likely. When patients with mental illness or SUD are unable to access the services they need early on, they become more likely to lose their jobs and turn to Medicaid—or enter the criminal justice system as a result of their disease.

¹⁸ Melek, S.P., Perlman, D., Davenport, S. (2017). Addiction and mental health vs. physical health: analyzing disparities in network use and provider reimbursement rates. *Milliman*.
<http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>

¹⁹ Rembert, M., Betz, M., Feng, B., Partridge, M. (2017). Taking measure of Ohio’s opioid crisis. *The Ohio State University, C. William Swank Program in Rural-Urban Policy*.
https://aede.osu.edu/sites/aede/files/publication_files/Swank%20-%20Taking%20Measure%20of%20Ohios%20Opioid%20Crisis.pdf

The child welfare system is also impacted when adults or children are unable to access treatment for mental illness or SUD. More than 15,000 children were in foster care in Ohio in 2017, representing a 23 percent increase since 2013, an increase that directly corresponds with the escalation of Ohio's opioid crisis.²⁰ The Ohio Department of Job and Family Services (ODJFS) estimates Ohio will have more than 20,000 children in the foster care system by 2020. Certainly strict enforcement of parity laws could help parents receive the treatment they need before their disease takes their lives or forces them to lose custody of their children. However, there are also children in Ohio's child welfare system whose parents voluntarily relinquished custody because they simply could not afford to pay for their children's complex care needs. These children are often referred to as "multi-system youth" because of their involvement in multiple public systems (e.g., child welfare, developmental disabilities, mental health and addiction services, juvenile justice, etc.). Parents of multi-system youth with complex care needs (particularly residential care) may see their insurance plan's benefit limits exhausted, or their insurer may deny services that should be covered under parity protections. In instances when Ohio parents cannot access the expensive services their children need, their only remaining choice may be to relinquish custody of their children so that they can receive those services in the child welfare system.²¹ Full enforcement of parity law and enhancing parent awareness of coverage rights under the law will be an important tool for policymakers seeking solutions to avoid this outcome.

RecoveryOhio recommendations

Almost immediately after taking office in January 2019, Governor DeWine issued an executive order creating the RecoveryOhio Advisory Council to inform the new administration's behavioral health policy platform. This body of leading experts, advocates and stakeholders recently published a report outlining 75 policy recommendations across eight priority areas.²² Improving enforcement and awareness of parity law was one of these eight key priorities. The report identified the following three recommendations to address parity in Ohio:

- **Alignment with the Mental Health Parity and Addiction Equity Act.** Align Ohio laws with the federal Mental Health Parity and Addiction Equity Act.
- **State Parity Coordination and Enforcement.** Coordinate across Ohio's state agencies to disseminate a concise definition of parity rights, enhance transparency and promote a feedback process to allow continuous improvement with clear benchmarks. The ODI should work with state departments, such as the Ohio Departments of Medicaid, Mental Health and Addiction Services, Health, Administration Services, and other appropriate departments, boards and commissions to achieve this goal. State agencies should also look at enforcement opportunities and their role in consumer protection.
- **Parity Education and Training.** Educate patients, families, employers, and professionals who serve the public — for example hospital staff, social workers and public health workers — to ensure understanding of insurance coverage rights and how to seek support with parity enforcement. Require that patients seeking treatment receive a notification of their parity rights

²⁰ Public Children's Services Association of Ohio. (2017). The opioid epidemic's impact on children's services in Ohio. <http://www.pcsao.org/pdf/advocacy/OpioidBriefingSlidesUpdated12-17.pdf>

²¹ Channing-Tenenbaum, G. (2019). Multi-system youth. *The Center for Community Solutions*. <https://www.communitysolutions.com/multi-system-youth/>

²² Office of Governor Mike DeWine. (2019). RecoveryOhio Advisory Council initial report. <https://governor.ohio.gov/wps/portal/gov/governor/media/news-and-media/031419a>

similar to notifications regarding the Health Insurance Portability and Accountability Act (HIPAA).”²³

While the language in the second and third recommendations are fairly straightforward, the first requires additional explanation. The sections of the Ohio Revised Code pertaining to insurance law have never been revised to align with federal parity law since MHPAEA was passed in 2008. An analysis of Ohio statute by the Parity at 10 campaign identified 12 unique sections of the Ohio Revised Code that are in conflict with MHPAEA. Specifically, current Ohio statute limits the scope of services in coverage mandates, and allows for financial requirements and nonquantitative treatment limitations in ways that are out of alignment with MHPAEA.²⁴

- **Scope of services.** Ohio insurance law mandates coverage of biologically-based mental illness, outpatient mental health care and outpatient and inpatient alcoholism treatment. Under MHPAEA, these coverage mandates trigger a requirement for health plans to cover a full scope of benefits, since the law requires plans that cover MH/SUD benefits to cover them in any of the six benefit classifications in which they cover medical/surgical benefits.
- **Financial requirements.** Ohio’s outpatient mental health and alcoholism coverage mandates authorize plans to establish annual benefit limits and financial requirements without referencing MHPAEA requirements.
- **Nonquantitative treatment limitations.** Multiple provisions in the Revised Code allow for plans to employ utilization management techniques such as prior authorization requirements, treatment plan reviews, negotiation of reimbursement rates and limits on location of service without requiring MHPAEA compliance.

Aligning Ohio’s law with MHPAEA is necessary to strengthen the legal recourse for violations of parity law by insurers when they occur. Ohio also has the opportunity to pass parity legislation that offers protections beyond those contained in MHPAEA. Illinois recently passed a model parity law that goes beyond MHPAEA by prohibiting prior authorization and step therapy for medication assisted treatment for opioid use disorder, and creating strict oversight and reporting requirements for state regulators to enforce MHPAEA.²⁵

Parity and Medicaid

Ohio’s recent Behavioral Health Redesign further heightened the urgency of enforcing parity law. MHPAEA does not apply to government health insurance plans such as Medicaid, Medicare and the Children’s Health Insurance Program (CHIP) under a fee-for-service model. However, managed care organizations that contract with state Medicaid programs are required to comply with parity requirements. Ohio carved its Medicaid behavioral health benefit into managed care in July 2018, triggering parity requirements. Since 90 percent of Ohio’s Medicaid recipients receive their benefits through managed care, the insurance plans of more than 2.6 million Ohioans became newly subject to parity law due to Behavioral Health Redesign.²⁶ The Ohio Department of Medicaid released a report prior

²³ Office of Governor Mike DeWine. (2019). RecoveryOhio Advisory Council initial report. <https://governor.ohio.gov/wps/portal/gov/governor/media/news-and-media/031419a>

²⁴ Parity at 10. (2018). A roadmap for parity reform in Ohio’s state-regulated private insurance market.

²⁵ ParityTrack. (2019). Statutory overview in Illinois. <https://www.paritytrack.org/report/illinois/illinois-law/>

²⁶ Ohio Department of Medicaid. (2019). Caseload report, April 2019. <https://medicaid.ohio.gov/Portals/0/Resources/Reports/Caseload/2019/04-Caseload.pdf>

to the July 2018 carve-in asserting that all of the Medicaid plans were in compliance with MHPAEA,²⁷ but no parity evaluation of the plans has been published since the carve-in has actually been in effect.

Conclusion

The early months of the DeWine administration have fostered a substantial political will to make meaningful policy changes and investments to promote recovery from mental illness and SUD. The RecoveryOhio Advisory Council has already been a powerful vehicle for shaping the governor's budget proposals for behavioral health initiatives. Given that this body has already identified parity as one of eight key priorities for moving the state toward recovery, there is a clear opportunity to strengthen Ohio's parity laws and improve enforcement under this administration and legislature. Private insurance companies play an outsized role in addressing Ohio's prolonged opioid crisis. Improving consumer awareness of coverage rights and strengthening regulatory protections of those rights is critical toward ensuring private insurance is a pathway, rather than a barrier to recovery.



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²⁷ Ohio Department of Medicaid. (2018). MHPAEA final report. <https://medicaid.ohio.gov/Portals/0/Providers/OH-MHPAEA-Final-Report.pdf>