House Bill 2608

Sponsored by Representative HANNA; Representatives GILLIAM, MAURER, OLSON, THATCHER, THOMPSON, WINGARD

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Director of Department of Consumer and Business Services to adopt rules allowing insurers to offer health insurance policies excluding benefits or coverage of specified conditions and services otherwise required by law. Requires written notification to and acknowledgment of notification by insured of exclusions under policy.

A BILL FOR AN ACT

Relating to health insurance coverage; creating new provisions; and amending ORS 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.088, 743A.100, 743A.104, 743A.108, 743A.110, 743A.120, 743A.124, 743A.140, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.180, 743A.184, 743A.188 and 743A.190.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2009 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) The Director of the Department of Consumer and Business Services shall adopt rules to authorize an insurer to offer a policy or certificate of health insurance in this state that excludes benefits or coverage required by one or more of the following sections:

(a) ORS 743A.062.

(b) ORS 743A.064.

(c) ORS 743A.066.

(d) ORS 743A.068.

(e) ORS 743A.070.

(f) ORS 743A.080.

(g) ORS 743A.088.

(h) ORS 743A.100.

(i) ORS 743A.104.

(j) ORS 743A.108.

(k) ORS 743A.110.

(L) ORS 743A.120.

(m) ORS 743A.124.

(n) ORS 743A.140.

(o) ORS 743A.144.

(p) ORS 743A.148.

(q) ORS 743A.160.

(r) ORS 743A.164.

(s) ORS 743A.168.

(t) ORS 743A.180.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(u) ORS 743A.184.

(v) ORS 743A.188.

(w) ORS 743A.190.

(2) An insurer offering a policy or certificate of health insurance that limits benefits or coverage pursuant to this section shall provide to the insured a written statement of the excluded benefits or coverage.

(3) A policy or certificate of health insurance may not be issued or renewed until the insured has signed a form acknowledging receipt of the written statement of the excluded benefits or coverage.

SECTION 3. ORS 743A.062 is amended to read:

743A.062. (1) [*No*] **Except as provided in section 2 of this 2009 Act, an** insurance policy or contract providing coverage for a prescription drug to a resident of this state [*shall*] **may not** exclude coverage of that drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if the Health Resources Commission determines that the drug is recognized as effective for the treatment of that indication:

(a) In publications that the commission determines to be equivalent to:

(A) The American Hospital Formulary Services drug information;

(B) "Drug Facts and Comparisons" (Lippincott-Raven Publishers);

(C) The United States Pharmacopoeia drug information; or

(D) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;

(b) In the majority of relevant peer-reviewed medical literature; or

(c) By the United States Secretary of Health and Human Services.

(2) Required coverage of a prescription drug under this section shall include coverage for medically necessary services associated with the administration of that drug.

(3) Nothing in this section requires coverage for any prescription drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

(4) Nothing in this section requires coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration.

(5) This section is exempt from ORS 743A.001.

SECTION 4. ORS 743A.064 is amended to read:

743A.064. (1) All health insurance policies that provide a prescription drug benefit, except those policies in which coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this subsection **or that are limited pursuant to section 2 of this 2009 Act**, must include coverage for prescription drugs dispensed by a licensed practitioner at a rural health clinic for an urgent medical condition if there is not a pharmacy within 15 miles of the clinic or if the prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic.

(2) The coverage required by subsection (1) of this section is subject to the terms and conditions of the prescription drug benefit provided under the policy.

(3) As used in this section, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

SECTION 5. ORS 743A.066 is amended to read:

743A.066. (1) **Except as provided in section 2 of this 2009 Act,** a prescription drug benefit

program, or a prescription drug benefit offered under a health benefit plan as defined in ORS 743.730 or under a student health insurance policy, must provide payment, coverage or reimbursement for:

(a) Prescription contraceptives; and

(b) If covered for other drug benefits under the program, plan or policy, outpatient consultations, examinations, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive.

(2) The coverage required by subsection (1) of this section may be subject to provisions of the program, plan or policy that apply equally to other prescription drugs covered by the program, plan or policy, including but not limited to required copayments, deductibles and coinsurance.

(3) As used in this section, "contraceptive" means a drug or device approved by the United States Food and Drug Administration to prevent pregnancy.

(4) A religious employer is exempt from the requirements of this section with respect to a prescription drug benefit program or a health benefit plan it provides to its employees. A "religious employer" is an employer:

(a) Whose purpose is the inculcation of religious values;

(b) That primarily employs persons who share the religious tenets of the employer;

(c) That primarily serves persons who share the religious tenets of the employer; and

(d) That is a nonprofit organization under section 6033(a)(2)(A)(i) or (iii) of the Internal Revenue Code.

(5) This section is exempt from the provisions of ORS 743A.001.

SECTION 6. ORS 743A.068 is amended to read:

743A.068. (1) **Except as provided in section 2 of this 2009 Act,** a health benefit plan that provides coverage for cancer chemotherapy treatment must provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

(2) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

(3) The provisions of ORS 743A.001 do not apply to this section.

SECTION 7. ORS 743A.070 is amended to read:

743A.070. (1) All policies providing health insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section **or limited pursuant to section 2 of this 2009 Act**, shall include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

(2) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas shall be no greater than those for any other treatment for the condition under the policy.

SECTION 8. ORS 743A.080 is amended to read:

743A.080. **Except as provided in section 2 of this 2009 Act,** all health benefit plans as defined in ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care, as defined by ORS 743.845, and childbirth. Benefits provided under this section shall be ex-

tended to all enrollees, enrolled spouses and enrolled dependents.

SECTION 9. [*No*] ORS 743A.088 is amended to read:

743A.088. [*No*] **Except as provided in section 2 of this 2009 Act, a** policy of health insurance may **not** be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth.

SECTION 10. ORS 743A.100 is amended to read:

743A.100. (1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases **or limited pursuant to section 2 of this 2009 Act**, shall provide coverage of mammograms as follows:

(a) Mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time upon referral of the woman's health care provider; and

(b) An annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health care provider.

(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the woman is determined by her health care provider to be at high risk for breast cancer.

SECTION 11. ORS 743A.104 is amended to read:

743A.104. All policies providing health insurance, except those policies [*whose coverage is limited*] **limiting coverage pursuant to section 2 of this 2009 Act or limiting coverage** to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:

(1) Annually for women 18 to 64 years of age; and

(2) At any time upon referral of the woman's health care provider.

SECTION 12. ORS 743A.108 is amended to read:

743A.108. (1) **Except as provided in section 2 of this 2009 Act,** a health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for a complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

(a) Annually for women 18 years of age and older; and

(b) At any time at the recommendation of the woman's health care provider.

(2) An insurance policy must provide coverage of physical examinations of the breast as described in subsection (1) of this section regardless of whether a health care provider performs other preventative women's health examinations or makes a referral for other preventative women's health examinations at the same time the health care provider performs the breast examination.

(3) This section applies to health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301.

SECTION 13. ORS 743A.110 is amended to read:

743A.110. (1) **Except as provided in section 2 of this 2009 Act,** all insurers offering a health benefit plan as defined in ORS 743.730 shall provide payment, coverage or reimbursement for the following mastectomy-related services as determined by the attending physician and enrollee to be part of the enrollee's course or plan of treatment:

(a) All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses;

(d) Treatment of physical complications of the mastectomy, including lymphedemas; and

(e) Inpatient care related to the mastectomy and post-mastectomy services.

(2) An insurer providing coverage under subsection (1) of this section shall provide written notice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and annually thereafter.

(3) A health benefit plan must provide a single determination of prior authorization for all mastectomy-related services covered under subsection (1) of this section that are part of the enrollee's course or plan of treatment.

(4) When an enrollee requests an external review of an adverse decision by the insurer regarding services described in subsection (1) of this section, the insurer must expedite the enrollee's case pursuant to ORS 743.857 (4).

(5) The coverage required under subsection (1) of this section is subject to the same terms and conditions in the plan that apply to other benefits under the plan.

(6) This section is exempt from ORS 743A.001.

SECTION 14. ORS 743A.120 is amended to read:

743A.120. (1) An insurer offering a health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases **or limited pursuant to section 2 of this 2009 Act**, shall provide coverage for prostate cancer screening examinations including a digital rectal examination and a prostate-specific antigen test:

(a) For men who are 50 years of age or older biennially or as determined by the treating physician; and

(b) For men younger than 50 years of age who are at high risk for prostate cancer as determined by the treating physician, including African-American men and men with a family medical history of prostate cancer.

(2) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301, are subject to subsection (1) of this section.

SECTION 15. ORS 743A.124 is amended to read:

743A.124. (1) An insurer offering a health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases **or limited pursuant to section 2 of this 2009 Act**, shall provide coverage for the following colorectal cancer screening examinations and laboratory tests:

(a) For an insured 50 years of age or older:

(A) One fecal occult blood test per year plus one flexible sigmoidoscopy every five years;

(B) One colonoscopy every 10 years; or

(C) One double contrast barium enema every five years.

(b) For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

(2) For the purposes of subsection (1)(b) of this section, an individual is at high risk for colorectal cancer if the individual has:

(a) A family medical history of colorectal cancer;

(b) A prior occurrence of cancer or precursor neoplastic polyps;

(c) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel dis-

ease, Crohn's disease or ulcerative colitis; or

(d) Other predisposing factors.

(3) Health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301, are also subject to this section.

SECTION 16. ORS 743A.140 is amended to read:

743A.140. (1) **Except as provided in section 2 of this 2009 Act,** whenever any policy of health insurance provides for reimbursement of a cochlear implant, the insured under the policy is entitled to coverage of bilateral cochlear implants.

(2) For purposes of ORS 746.230, a reasonable investigation of a claim for bilateral cochlear implants must include a request to the treating surgeon for a written recommendation based on peer-reviewed medical literature and for the medical findings that support the recommendation.

(3) The provisions of this section apply to a health benefit plan as defined in ORS 743.730.

(4) The provisions of this section are exempt from ORS 743A.001.

SECTION 17. ORS 743A.144 is amended to read:

743A.144. (1) **Except as provided in section 2 of this 2009 Act,** all individual and group health insurance policies providing coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

(2) As used in this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

(b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(3) The Director of the Department of Consumer and Business Services shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this section. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

(4) The coverage required by subsection (1) of this section may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

(5) The coverage required by subsection (1) of this section shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(6) If coverage under subsection (1) of this section is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct Oregon prosthetic and orthotic providers in the managed care plan's provider network.

SECTION 18. ORS 743A.148 is amended to read:

743A.148. (1) [*The Legislative Assembly declares that*] **Except as provided in section 2 of this 2009 Act,** all group health insurance policies providing hospital, medical or surgical expense benefits **shall** include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

[*(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982.*]

SECTION 19. ORS 743A.160 is amended to read:

743A.160. A health insurance policy [*providing*] **that provides** coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses **and that is not limited pursuant to section 2 of this 2009 Act** shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of the applicant's option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by the following facilities:

(a) A health care facility licensed as required by ORS 441.015.

(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $4,500 in any 24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism.

SECTION 20. ORS 743A.164 is amended to read:

743A.164. **(1)** A health insurance policy [*other than a disability income policy*] shall provide coverage or reimbursement of expenses for the medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance to the same extent as and subject to limitations no more restrictive than those imposed on coverage or reimbursement of expenses arising from treatment of injuries or illnesses not caused by an insured's use of alcohol or a controlled substance.

(2) This section does not apply to a disability income policy or a policy offered pursuant to section 2 of this 2009 Act.

SECTION 21. ORS 743A.168 is amended to read:

743A.168. [*A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:*]

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(A) A health care facility;

(B) A residential program or facility;

(C) A day or partial hospitalization program;

(D) An outpatient service; or

(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

(2) Except as provided in section 2 of this 2009 Act, a group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

[*(2)*] **(3)** The coverage **required by subsection (2) of this section:**

(a) May be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

[*(3) The coverage*] **(b)** May not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. [*The coverage of eligible expenses*]

(c) May be limited to treatment that is medically necessary as determined under the policy for

other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) A screening interview or treatment program under ORS 813.021.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved by the Department of Human Services;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to licensed clinical social workers, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist

Examiners or a clinical social worker licensed by the State Board of Clinical Social Workers, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all eligible providers.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress.

(14) The Director of the Department of Consumer and Business Services, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions.

SECTION 22. ORS 743A.180 is amended to read:

743A.180. **(1)** For [*purpose*] **purposes** of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed.

(2) This section does not apply to a policy or certificate of health insurance offered pursuant to section 2 of this 2009 Act.

SECTION 23. ORS 743A.184 is amended to read:

743A.184. (1) Subject to other terms, conditions and benefits in the plan, group health benefit plans as described in ORS 743.730 shall provide payment, coverage or reimbursement for supplies, equipment and diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes pre-

scribed by a health care professional legally authorized to prescribe such items.

(2) As used in this section, "diabetes self-management program" means one program of assessment and training after diagnosis and no more than three hours per year of assessment and training upon a material change of condition, medication or treatment that is provided by:

(a) An education program credentialed or accredited by a state or national entity accrediting such programs; or

(b) A program provided by a physician licensed under ORS chapter 677, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes.

(3) This section does not apply to a health benefit plan offered pursuant to section 2 of this 2009 Act.

SECTION 24. ORS 743A.188 is amended to read:

743A.188. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases **or limited pursuant to section 2 of this 2009 Act**, shall include coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

(2) As used in this section, "medical foods" means foods that are formulated to be consumed or administered enterally under the supervision of a physician, as defined in ORS 677.010, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

(3) This section is exempt from ORS 743A.001.

SECTION 25. ORS 743A.190 is amended to read:

743A.190. (1) **Except as provided in section 2 of this 2009 Act,** a health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b) "Pervasive developmental disorder" means a neurological condition that includes Asperger's

syndrome, autism, developmental delay, developmental disability or mental retardation.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168.

SECTION 26. Section 2 of this 2009 Act and the amendments to ORS 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.088, 743A.100, 743A.104, 743A.108, 743A.110, 743A.120, 743A.124, 743A.140, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.180, 743A.184, 743A.188 and 743A.190 by sections 3 to 25 of this 2009 Act apply to policies or certificates of health insurance issued or renewed on or after the effective date of this 2009 Act.