House Bill 3164

Sponsored by Representative BUCKLEY

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.**

Expands required health insurance coverage of professional counselor or marriage and family therapist services to include services provided by counselor or therapist authorized to practice without license. Modifies requirements for coverage of mental health treatment.

1 **A BILL FOR AN ACT**

2 Relating to health insurance coverage for mental health services; creating new provisions; and
3 amending ORS 743A.052 and 743A.168.

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

5 **SECTION 1.** ORS 743A.052 is amended to read:

6 743A.052. (1) If a group health benefit plan, as described in ORS 743.730, provides for coverage
7 for services performed by a clinical social worker or nurse practitioner, the plan also must cover
8 services provided by a professional counselor or marriage and family therapist [*licensed under ORS*
9 *675.715 to 675.835*] when the counselor or therapist is acting within the counselor's or therapist's
10 lawful scope of practice **and the counselor or therapist is:**

11 **(a) Licensed under ORS 675.715 to 675.835; or**

12 **(b) Authorized to provide professional counseling or marriage and family therapy without**
13 **a license under ORS 675.825 (3)(c) or (d)**.

14 (2) Health maintenance organizations may limit the receipt of covered services performed by
15 professional counselors and marriage and family therapists to services provided by or upon referral
16 by providers contracting with the health maintenance organization. Health maintenance organiza-
17 tions and health care service contractors may create substantive plan benefit and reimbursement
18 differentials at the same level as, and subject to limitations not more restrictive than, those imposed
19 on coverage or reimbursement of expenses arising out of other medical conditions and apply them
20 to contracting and noncontracting providers.

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

22 **SECTION 2.** ORS 743A.168 is amended to read:

23 743A.168. A group health insurance policy providing coverage for hospital or medical expenses
24 shall provide coverage for expenses arising from treatment for chemical dependency, including
25 alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no
26 more restrictive than, those imposed on coverage or reimbursement of expenses arising from treat-
27 ment for other medical conditions. The following apply to coverage for chemical dependency and for
28 mental or nervous conditions:

29 (1) As used in this section:

30 (a) "Chemical dependency" means the addictive relationship with any drug or alcohol charac-
31 terized by a physical or psychological relationship, or both, that interferes on a recurring basis with

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.

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) 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. 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 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 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**; or**

(F) Support groups.

(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) **Except as provided in subsection (4) of this section,** a provider is eligible for reimbursement under this section **for services provided to a patient** if:

(a) The provider is approved by the Department of Human Services **or the Oregon Health Authority to provide the 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*] **The requirements for reimbursement under subsection (5) of this section do not supersede or limit other provisions of the Insurance Code requiring coverage or prohibiting exclusion of coverage for specified conditions, services, persons or providers**.

(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, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, 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, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, 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 3. The amendments to ORS 743A.052 and 743A.168 apply to insurance policies or certificates issued or renewed on or after the effective date of this 2011 Act.