PRELIMINARY

HB 3046 -1, -2 STAFF MEASURE SUMMARY

House Committee On Behavioral Health

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Meeting Dates:	2/17, 4/5

WHAT THE MEASURE DOES:

Specifies behavioral health treatments coordinate care organizations (CCOs), group health insurance policies or individual health benefit plan are required to provide. Prohibits making behavioral health treatment subject to prior authorization except as by Oregon Health Authority (OHA) rule. Defines terms. Prohibits limiting behavioral health coverage for treatment of pervasive or chronic behavioral health condition to short term or acute behavioral health treatment at any level of care or placement. Requires insurers to have sufficient network of providers. Requires outpatient coverage of behavioral health treatment to include follow up in-home service or outpatient services if clinically indicated. Limits utilizations reviews to be based solely on standard of care and clinical practices and valid, evidence-based sources. Requires insurer to sponsor formal education program by nonprofit clinical specialty association to educate reviewers, make education program available to other stakeholders, provide clinical review criteria to providers and insureds at no cost, track how clinical review criteria are used in the appeals process, and assess interrater review reliability. Prohibits insurer from rescinding or modifying authorization after provider delivers treatment. Prohibits group health insurance policy or individual health plan from containing provision that reserves sole authority to determine eligibility of benefits coverage. Replaces "chemical dependency" with "behavioral health condition."

REVENUE: May have revenue impact, but no statement yet issued.

FISCAL: May have fiscal impact, but no statement yet issued.

ISSUES DISCUSSED:

- Reimbursement rates for behavioral health providers
- Barriers to accessing behavioral health care

EFFECT OF AMENDMENT:

-1 Prohibits insurer from withholding payment from provider while conducting utilization review before adverse benefit determination.

-2 Defines terms. Requires carriers that administer claims for behavioral health benefits conduct annual review of the design and application of medical necessity criteria and benefit limitations on mental health and substance use disorder benefits in comparison to medical and surgical benefits and submit those analyses to the Department of Consumer Business Services(DCBS) and the Oregon Health Authority (OHA) on March 1st of each year. Requires agencies to report to Legislative Assembly by September 15th of each year. Directs DCBS to establish mental health parity advisory committee. Adds treatment of the unique needs of older adults to list of treatments that must be covered. Requires group insurer or individual benefit plan to use same methodology to set reimbursement rates for behavioral health treatment providers as is used for medical and surgical treatment providers. Directs DCBS and OHA to adopt rules making it a violation to require providers to bill with specific billing codes or restrict reimbursement to particular codes, unless based on medical necessity. Requires DCBS to to evaluate insurers network of mental and behavioral health providers for an adequate number and geographic distribution to meet needs of different groups of enrollees.

BACKGROUND:

In 2017, The Oregon State Legislature passed House Bill 3091, which requires coordinated care organizations (CCOs) to provide and prioritize specified behavioral health services for members, including behavioral health assessments and medically necessary treatments to members in behavioral health crisis.

House Bill 3046 specifies behavioral health treatment that must be provided by CCOs and covered by group health insurance and individual health plans.

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