

B-Engrossed
House Bill 3046

Ordered by the House June 23
Including House Amendments dated April 15 and June 23

Sponsored by Representative NOSSE; Representatives CAMPOS, LIVELY, MORGAN, PRUSAK, REYNOLDS, SALINAS, SANCHEZ, WRIGHT

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.

Specifies behavioral health treatment that must be provided by coordinated care organizations and covered by group health insurance and individual health plans and restricts utilization review criteria for behavioral health treatment.

Requires carriers and coordinated care organizations to conduct analyses of compliance with mental health parity requirements and report specified data to Department of Consumer and Business Services and Oregon Health Authority respectively.

A BILL FOR AN ACT

1
2 Relating to behavioral health; creating new provisions; and amending ORS 414.766, 743A.168 and
3 743B.505.

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

5 **SECTION 1. Section 2 of this 2021 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. (1) As used in this section:**

7 (a) **“Behavioral health benefits” means insurance coverage of mental health treatment**
8 **and services and substance use disorder treatment and services.**

9 (b) **“Carrier” has the meaning given that term in ORS 743B.005.**

10 (c) **“Geographic region” means the geographic area of the state established by the De-**
11 **partment of Consumer and Business Services for the purpose of determining geographic av-**
12 **erage rates, as defined in ORS 743B.005.**

13 (d) **“Health benefit plan” has the meaning given that term in ORS 743B.005.**

14 (e) **“Median maximum allowable reimbursement rate” means the median of all maximum**
15 **allowable reimbursement rates, minus incentive payments, paid for each billing code for each**
16 **provider type during a calendar year.**

17 (f) **“Mental health treatment and services” means the treatment of or services provided**
18 **to address any condition or disorder that falls under any of the diagnostic categories listed**
19 **in the mental disorders section of the current edition of the:**

20 (A) **International Classification of Disease; or**

21 (B) **Diagnostic and Statistical Manual of Mental Disorders.**

22 (g) **“Nonquantitative treatment limitation” means a limitation that is not expressed nu-**
23 **merically but otherwise limits the scope or duration of behavioral health benefits.**

24 (h) **“Substance use disorder treatment and services” means the treatment of or services**
25 **provided to address any condition or disorder that falls under any of the diagnostic catego-**

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.

1 ries listed in the substance use section of the current edition of the:

2 (A) International Classification of Disease; or

3 (B) Diagnostic and Statistical Manual of Mental Disorders.

4 (2) Each carrier that offers an individual or group health benefit plan in this state that
5 provides behavioral health benefits shall conduct an annual analysis of whether the pro-
6 cesses, strategies, specific evidentiary standards or other factors the carrier used to design,
7 determine applicability of and apply each nonquantitative treatment limitation to behavioral
8 health benefits within each classification of benefits are comparable to, and are applied no
9 more stringently than, the processes, strategies, specific evidentiary standards or other
10 factors the carrier used to design, determine applicability of and apply each nonquantitative
11 treatment limitation to medical and surgical benefits within the corresponding classification
12 of benefits.

13 (3) On or before March 1 of each year, all carriers that offer individual or group health
14 benefit plans in this state that provide behavioral health benefits shall report to the De-
15 partment of Consumer and Business Services, in the form and manner prescribed by the
16 department, the following information:

17 (a) The specific plan or coverage terms or other relevant terms regarding the nonquan-
18 titative treatment limitations and a description of all mental health or substance use disor-
19 der and medical or surgical benefits to which each such term applies in each respective
20 benefits classification.

21 (b) The factors used to determine that the nonquantitative treatment limitations will
22 apply to mental health or substance use disorder benefits and medical or surgical benefits.

23 (c) The evidentiary standards used for the factors identified in paragraph (b) of this
24 subsection, when applicable, provided that every factor is defined, and any other source or
25 evidence relied upon to design and apply the nonquantitative treatment limitations to mental
26 health or substance use disorder benefits and medical or surgical benefits.

27 (d) The comparative analyses demonstrating that the processes, strategies, evidentiary
28 standards and other factors used to apply the nonquantitative treatment limitations to
29 mental health or substance use disorder benefits, as written and in operation, are compara-
30 ble to, and are applied no more stringently than, the processes, strategies, evidentiary stan-
31 dards and other factors used to apply the nonquantitative treatment limitations to medical
32 or surgical benefits in the benefits classification.

33 (e) The specific findings and conclusions reached by the insurer with respect to the
34 health insurance coverage, including any results of the analyses described in paragraphs (a)
35 to (d) of this subsection that indicate that the plan or coverage is or is not in compliance
36 with this section.

37 (f) The number of denials of behavioral health benefits and medical and surgical benefits,
38 the percentage of denials that were appealed, the percentage of appeals that upheld the de-
39 nial and the percentage of appeals that overturned the denial.

40 (g) The percentage of claims for behavioral health benefits and medical and surgical
41 benefits that were paid to in-network providers and the percentage of such claims that were
42 paid to out-of-network providers.

43 (h) The median maximum allowable reimbursement rate for each time-based office visit
44 billing code for each behavioral treatment provider type and each medical provider type.

45 (i) The reimbursement rate in each geographic region for a time-based office visit and

1 the percentage of the Medicare rate the reimbursement rate represents, paid to:

- 2 (A) Psychiatrists.
- 3 (B) Psychiatric mental health nurse practitioners.
- 4 (C) Psychologists.
- 5 (D) Licensed clinical social workers.
- 6 (E) Licensed professional counselors.
- 7 (F) Licensed marriage and family therapists.

8 (j) The reimbursement rate in each geographic region for a time-based office visit and
9 the percentage of the Medicare rate the reimbursement rate represents, paid to:

- 10 (A) Physicians.
- 11 (B) Physician assistants.
- 12 (C) Licensed nurse practitioners.

13 (k) The specific findings and conclusions of the carrier under subsection (2) of this sec-
14 tion demonstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici
15 Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted
16 thereunder.

17 (L) Other data or information the department deems necessary to assess a carrier's
18 compliance with mental health parity requirements.

19 (4) No later than September 15 of each calendar year, the department shall report to the
20 interim committees of the Legislative Assembly related to mental or behavioral health, in
21 the manner provided in ORS 192.245, the information reported under subsection (3) of this
22 section, including the department's overall comparison of carriers' coverage of mental health
23 treatment and services and substance use disorder treatment and services to carriers' cov-
24 erage of medical or surgical treatments or services.

25 **SECTION 3.** (1) As used in this section:

26 (a) "Behavioral health coverage" means mental health treatment and services and sub-
27 stance use disorder treatment or services reimbursed by a coordinated care organization.

28 (b) "Coordinated care organization" has the meaning given that term in ORS 414.025.

29 (c) "Mental health treatment and services" means the treatment of or services provided
30 to address any condition or disorder that falls under any of the diagnostic categories listed
31 in the mental disorders section of the current edition of the:

- 32 (A) International Classification of Disease; or
- 33 (B) Diagnostic and Statistical Manual of Mental Disorders.

34 (d) "Nonquantitative treatment limitation" means a limitation that is not expressed nu-
35 merically but otherwise limits the scope or duration of behavioral health coverage, such as
36 medical necessity criteria or other utilization review.

37 (e) "Substance use disorder treatment and services" means the treatment of and any
38 services provided to address any condition or disorder that falls under any of the diagnostic
39 categories listed in the substance use section of the current edition of the:

- 40 (A) International Classification of Disease; or
- 41 (B) Diagnostic and Statistical Manual of Mental Disorders.

42 (2) No later than March 1 of each calendar year, the Oregon Health Authority shall pre-
43 scribe the form and manner for each coordinated care organization to report to the author-
44 ity, on or before June 1 of the calendar year, information about the coordinated care
45 organization's compliance with mental health parity requirements, including but not limited

1 to the following:

2 (a) The specific plan or coverage terms or other relevant terms regarding the nonquan-
3 titative treatment limitations and a description of all mental health or substance use disor-
4 der benefits and medical or surgical benefits to which each such term applies in each
5 respective benefits classification.

6 (b) The factors used to determine that the nonquantitative treatment limitations will
7 apply to mental health or substance use disorder benefits and medical or surgical benefits.

8 (c) The evidentiary standards used for the factors identified in paragraph (b) of this
9 subsection, when applicable, provided that every factor is defined, and any other source or
10 evidence relied upon to design and apply the nonquantitative treatment limitations to mental
11 health or substance use disorder benefits and medical or surgical benefits.

12 (d) The number of denials of coverage of mental health treatment and services, substance
13 use disorder treatment and services and medical and surgical treatment and services, the
14 percentage of denials that were appealed, the percentage of appeals that upheld the denial
15 and the percentage of appeals that overturned the denial.

16 (e) The percentage of claims for behavioral health coverage and for coverage of medical
17 and surgical treatments that were paid to in-network providers and the percentage of such
18 claims that were paid to out-of-network providers.

19 (f) Other data or information the authority deems necessary to assess a coordinated care
20 organization's compliance with mental health parity requirements.

21 (3) Coordinated care organizations must demonstrate in the documentation submitted
22 under subsection (2) of this section, that the processes, strategies, evidentiary standards and
23 other factors used to apply nonquantitative treatment limitation to mental health or sub-
24 stance use disorder treatment, as written and in operation, are comparable to and are ap-
25 plied no more stringently than the processes, strategies, evidentiary standards and other
26 factors used to apply nonquantitative treatment limitations to medical or surgical treat-
27 ments in the same classification.

28 (4) Each calendar year the authority, in collaboration with individuals representing be-
29 havioral health treatment providers, community mental health programs, coordinated care
30 organizations, the Consumer Advisory Council established in ORS 430.073 and consumers of
31 mental health or substance use disorder treatment, shall, based on the information reported
32 under subsection (2) of this section, identify and assess:

33 (a) Coordinated care organizations' compliance with the requirements for parity between
34 the behavioral health coverage and the coverage of medical and surgical treatment in the
35 medical assistance program; and

36 (b) The authority's compliance with the requirements for parity between the behavioral
37 health coverage and the coverage of medical and surgical treatment in the medical assist-
38 ance program for individuals who are not enrolled in a coordinated care organization.

39 (5) No later than December 31 of each calendar year, the authority shall submit a report
40 to the interim committees of the Legislative Assembly related to mental or behavioral
41 health, in the manner provided in ORS 192.245, that includes:

42 (a) The authority's findings under subsection (4) of this section on compliance with rules
43 regarding mental health parity, including a comparison of coverage for members of coordi-
44 nated care organizations to coverage for medical assistance recipients who are not enrolled
45 in coordinated care organizations as applicable; and

1 (b) An assessment of:

2 (A) The adequacy of the provider network as prescribed by the authority by rule.

3 (B) The timeliness of access to mental health and substance use disorder treatment and
4 services, as prescribed by the authority by rule.

5 (C) The criteria used by each coordinated care organization to determine medical neces-
6 sity and behavioral health coverage, including each coordinated care organization's payment
7 protocols and procedures.

8 (D) Data on services that are requested but that coordinated care organizations are not
9 required to provide.

10 (E) The consistency of credentialing requirements for behavioral health treatment pro-
11 viders with the credentialing of medical and surgical treatment providers.

12 (F) The utilization review, as defined by the authority by rule, applied to behavioral
13 health coverage compared to coverage of medical and surgical treatments.

14 (G) The specific findings and conclusions reached by the authority with respect to the
15 coverage of mental health and substance use disorder treatment and the authority's analysis
16 that indicates that the coverage is or is not in compliance with this section.

17 (H) The specific findings and conclusions of the authority demonstrating a coordinated
18 care organization's compliance with this section and with the Paul Wellstone and Pete
19 Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules
20 adopted thereunder.

21 (6) Except as provided in subsection (5)(b)(D) of this section, this section does not require
22 coordinated care organizations to report data on services that are not funded on the prior-
23 itized list of health services compiled by the Health Evidence Review Commission under ORS
24 414.690.

25 **SECTION 4.** ORS 414.766 is amended to read:

26 414.766. (1) Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must
27 provide behavioral health services to its members that include but are not limited to all of the fol-
28 lowing:

29 [(1)] (a) For a member who is experiencing a behavioral health crisis:

30 [(a)] (A) A behavioral health assessment; and

31 [(b)] (B) Services that are medically necessary to transition the member to a lower level of care;

32 [(2)] (b) At least the minimum level of services that are medically necessary to treat a member's
33 **underlying** behavioral health condition **rather than a mere amelioration of current symptoms,**
34 **such as suicidal ideation or psychosis,** as determined in a behavioral health assessment of the
35 member or specified in the member's care plan; [and]

36 (c) **Treatment of co-occurring behavioral health disorders or medical conditions in a co-**
37 **ordinated manner;**

38 (d) **Treatment at the least intensive and least restrictive level of care that is safe and**
39 **effective and meets the needs of the individual's condition;**

40 (e) **For all level of care placement decisions, placement at the level of care consistent**
41 **with a member's score or assessment using the relevant level of care placement criteria and**
42 **guidelines;**

43 (f) **If the level of placement described in paragraph (e) of this subsection is not available,**
44 **placement at the next higher level of care;**

45 (g) **Treatment to maintain functioning or prevent deterioration;**

1 (h) Treatment for an appropriate duration based on the individual's particular needs;

2 (i) Treatment appropriate to the unique needs of children and adolescents;

3 (j) Treatment appropriate to the unique needs of older adults;

4 (k) Treatment that is culturally and linguistically appropriate;

5 (L) Treatment that is appropriate to the unique needs of gay, lesbian, bisexual and
6 transgender individuals and individuals of any other minority gender identity or sexual ori-
7 entation; and

8 [(3)] (m) Coordinated care and case management as defined by the Department of Consumer and
9 Business Services by rule.

10 (2) If there is a disagreement about the level of care required by subsection (1)(e) or (f)
11 of this section, a coordinated care organization shall provide to the behavioral health treat-
12 ment provider full details of the coordinated care organization's scoring or assessment, to
13 the extent permitted by the federal Health Insurance Portability and Accountability Act
14 privacy regulations, 45 C.F.R. parts 160 and 164, ORS 192.553 to 192.581 or other state or
15 federal laws limiting the disclosure of health information.

16 (3) The Oregon Health Authority shall adopt by rule a list of behavioral health services
17 that may not be subject to prior authorization.

18 **SECTION 5.** ORS 743A.168 is amended to read:

19 743A.168. (1) As used in this section:

20 (a) "Behavioral health assessment" means an evaluation by a provider, in person or using tele-
21 medicine, to determine a patient's need for behavioral health treatment.

22 (b) "Behavioral health condition" has the meaning prescribed by rule by the Department
23 of Consumer and Business Services.

24 [(b)] (c) "Behavioral health crisis" means a disruption in an [individual's] insured's mental or
25 emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in
26 an emergency department or admission to a hospital to prevent a serious deterioration in the
27 [individual's] insured's mental or physical health.

28 [(c) "Chemical dependency" means the addictive relationship with any drug or alcohol character-
29 ized by a physical or psychological relationship, or both, that interferes on a recurring basis with the
30 individual's social, psychological or physical adjustment to common problems. For purposes of this
31 section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco pro-
32 ducts or foods.]

33 (d) "Facility" means a corporate or governmental entity or other provider of services for the
34 treatment of [chemical dependency or for the treatment of mental or nervous conditions] **behavioral**
35 **health conditions.**

36 (e) "Generally accepted standards of care" means:

37 (A) Standards of care and clinical practice guidelines that:

38 (i) Are generally recognized by health care providers practicing in relevant clinical spe-
39 cialties; and

40 (ii) Are based on valid, evidence-based sources; and

41 (B) Products and services that:

42 (i) Address the specific needs of a patient for the purpose of screening for, preventing,
43 diagnosing, managing or treating an illness, injury or condition or symptoms of an illness,
44 injury or condition;

45 (ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and

1 (iii) **Are not primarily for the economic benefit of an insurer or payer or for the con-**
2 **venience of a patient, treating physician or other health care provider.**

3 [(e)] (f) “Group health insurer” means an insurer, a health maintenance organization or a health
4 care service contractor.

5 (g) **“Median maximum allowable reimbursement rate” means the median of all maximum**
6 **allowable reimbursement rates, minus incentive payments, paid for each billing code for each**
7 **provider type during a calendar year.**

8 [(f)] (h) “Prior authorization” has the meaning given that term in ORS 743B.001.

9 [(g)] (i) “Program” means a particular type or level of service that is organizationally distinct
10 within a facility.

11 [(h)] (j) “Provider” means:

12 (A) [An individual] **A behavioral health professional or medical professional licensed or**
13 **certified in this state** who has met the credentialing requirement of a group health insurer or an
14 issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS
15 743B.005[,] **and** is otherwise eligible to receive reimbursement for coverage under the policy [*and is*
16 *a behavioral health professional or a medical professional licensed or certified in this state*];

17 (B) A health care facility as defined in ORS 433.060;

18 (C) A residential facility as defined in ORS 430.010;

19 (D) A day or partial hospitalization program;

20 (E) An outpatient service as defined in ORS 430.010; or

21 (F) A provider organization certified by the Oregon Health Authority under subsection [(7)] (8)
22 of this section.

23 (k) **“Relevant clinical specialties” includes but is not limited to:**

24 (A) **Psychiatry;**

25 (B) **Psychology;**

26 (C) **Clinical sociology;**

27 (D) **Addiction medicine and counseling; and**

28 (E) **Behavioral health treatment.**

29 (L) **“Standards of care and clinical practice guidelines” includes but is not limited to:**

30 (A) **Patient placement criteria;**

31 (B) **Recommendations of agencies of the federal government; and**

32 (C) **Drug labeling approved by the United States Food and Drug Administration.**

33 [(i)] (m) “Utilization review” has the meaning given that term in ORS 743B.001.

34 (n) **“Valid, evidence-based sources” includes but is not limited to:**

35 (A) **Peer-reviewed scientific studies and medical literature;**

36 (B) **Recommendations of nonprofit health care provider professional associations; and**

37 (C) **Specialty societies.**

38 (2) A group health insurance policy or an individual health benefit plan that is not a grandfa-
39 thered health plan providing coverage for hospital or medical expenses, other than limited benefit
40 coverage, shall provide coverage for expenses arising from the diagnosis of **behavioral health**
41 **conditions** and **medically necessary behavioral health** treatment [*for chemical dependency, in-*
42 *cluding alcoholism, and for mental or nervous conditions*] at the same level as, and subject to limi-
43 tations no more restrictive than, those imposed on coverage or reimbursement of expenses arising
44 from treatment for other medical conditions. The following apply to coverage for [*chemical depend-*
45 *ency and for mental or nervous conditions*] **behavioral health treatment:**

1 (a) The coverage may be made subject to provisions of the policy that apply to other benefits
2 under the policy, including but not limited to provisions relating to **copayments**, deductibles and
3 coinsurance. **Copayments**, deductibles and coinsurance for treatment in health care facilities or
4 residential facilities may not be greater than those under the policy for expenses of hospitalization
5 in the treatment of other medical conditions. **Copayments**, deductibles and coinsurance for outpa-
6 tient treatment may not be greater than those under the policy for expenses of outpatient treatment
7 of other medical conditions.

8 (b) The coverage of **behavioral health treatment** may not be made subject to treatment limi-
9 tations, limits on total payments for treatment, limits on duration of treatment or financial require-
10 ments unless similar limitations or requirements are imposed on coverage of other medical
11 conditions. The coverage of eligible expenses of **behavioral health treatment** may be limited to
12 treatment that is medically necessary as determined **in accordance with this section and no more**
13 **stringently** under the policy **than** for other medical conditions.

14 (c) The coverage of **behavioral health treatment** must include:

15 (A) A behavioral health assessment;

16 (B) No less than the level of services determined to be medically necessary in a behavioral
17 health assessment of **the specific needs of** a patient or in a patient's care plan:

18 (i) To **effectively** treat the patient's **underlying** behavioral health condition **rather than the**
19 **mere amelioration of current symptoms such as suicidal ideation or psychosis**; and

20 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of
21 care; [*and*]

22 (C) **Treatment of co-occurring behavioral health conditions or medical conditions in a**
23 **coordinated manner**;

24 (D) **Treatment at the least intensive and least restrictive level of care that is safe and**
25 **most effective and meets the needs of the insured's condition**;

26 (E) **A lower level or less intensive care only if it is comparably as safe and effective as**
27 **treatment at a higher level of service or intensity**;

28 (F) **Treatment to maintain functioning or prevent deterioration**;

29 (G) **Treatment for an appropriate duration based on the insured's particular needs**;

30 (H) **Treatment appropriate to the unique needs of children and adolescents**;

31 (I) **Treatment appropriate to the unique needs of older adults**; and

32 [(C)] (J) **Coordinated care and case management as defined by the Department of Consumer and**
33 **Business Services by rule.**

34 (d) **The coverage of behavioral health treatment may not limit coverage for treatment**
35 **of pervasive or chronic behavioral health conditions to short-term or acute behavioral health**
36 **treatment at any level of care or placement.**

37 (e) **A group health insurer or an issuer of an individual health benefit plan other than a**
38 **grandfathered health plan shall have a network of providers of behavioral health treatment**
39 **sufficient to meet the standards described in ORS 743B.505. If there is no in-network provider**
40 **qualified to timely deliver, as defined by rule, medically necessary behavioral treatment to**
41 **an insured in a geographic area, the group health insurer or issuer of an individual health**
42 **benefit plan shall provide coverage of out-of-network medically necessary behavioral health**
43 **treatment without any additional out-of-pocket costs if provided by an available out-of-**
44 **network provider that enters into an agreement with the insurer to be reimbursed at in-**
45 **network rates.**

1 [(d)] (f) A provider is eligible for reimbursement under this section if:

2 (A) The provider is approved or certified by the Oregon Health Authority;

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

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

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

8 **(g) A group health insurer or an issuer of an individual health benefit plan other than a**
9 **grandfathered health plan must use the same methodology to set reimbursement rates paid**
10 **to behavioral health treatment providers that the group health insurer or issuer of an indi-**
11 **vidual health benefit plan uses to set reimbursement rates for medical and surgical treat-**
12 **ment providers.**

13 **(h) A group health insurer or an issuer of an individual health benefit plan other than a**
14 **grandfathered health plan must update the methodology and rates for reimbursing behavioral**
15 **health treatment providers in a manner equivalent to the manner in which the group health**
16 **insurer or issuer of an individual health benefit plan updates the methodology and rates for**
17 **reimbursing medical and surgical treatment providers, unless otherwise required by federal**
18 **law.**

19 **(i) A group health insurer or an issuer of an individual health benefit plan other than a**
20 **grandfathered health plan that reimburses out-of-network providers for medical or surgical**
21 **services must reimburse out-of-network behavioral health treatment providers on the same**
22 **terms and at a rate that is in parity with the rate paid to medical or surgical treatment**
23 **providers.**

24 [(e)] (j) [If specified in the policy,] Outpatient coverage of behavioral health treatment [may]
25 shall include follow-up in-home service or outpatient services if clinically indicated under any
26 medical necessity, utilization or other clinical review conducted for the diagnosis, prevention
27 or treatment of behavioral health conditions or relating to service intensity, level of care
28 placement, continued stay or discharge. The policy may limit coverage for in-home service to
29 persons who are homebound under the care of a physician only if clinically indicated under any
30 medical necessity, utilization or other clinical review conducted for the diagnosis, prevention
31 or treatment of behavioral health conditions or relating to service intensity, level of care
32 placement, continued stay or discharge.

33 [(f)(A)] (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating
34 to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS
35 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed
36 professional counselors and licensed marriage and family therapists, a group health insurer or issuer
37 of an individual health benefit plan may provide for review for level of treatment of admissions and
38 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization
39 programs and outpatient services by either staff of a group health insurer or issuer of an individual
40 health benefit plan or personnel under contract to the group health insurer or issuer of an individual
41 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,
42 who shall have the authority to certify for or deny level of payment.

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

45 (C) Review shall be performed by or under the direction of a physician licensed under ORS

1 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social
2 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-
3 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and
4 Therapists, in accordance with standards of the National Committee for Quality Assurance or
5 Medicare review standards of the Centers for Medicare and Medicaid Services.

6 (D) Review may involve prior approval, concurrent review of the continuation of treatment,
7 post-treatment review or any combination of these. However, if prior approval is required, provision
8 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
9 view. If prior approval is not required, group health insurers and issuers of individual health benefit
10 plans that are not grandfathered health plans shall permit providers, policyholders or persons acting
11 on their behalf to make advance inquiries regarding the appropriateness of a particular admission
12 to a treatment program. Group health insurers and issuers of individual health benefit plans that
13 are not grandfathered health plans shall provide a timely response to such inquiries. Noncontracting
14 providers must cooperate with these procedures to the same extent as contracting providers to be
15 eligible for reimbursement.

16 [(g)] (L) Health maintenance organizations may limit the receipt of covered services by enrollees
17 to services provided by or upon referral by providers contracting with the health maintenance or-
18 ganization. Health maintenance organizations and health care service contractors may create sub-
19 stantive plan benefit and reimbursement differentials at the same level as, and subject to limitations
20 no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of
21 other medical conditions and apply them to contracting and noncontracting providers.

22 (3) This section does not prohibit a group health insurer or issuer of an individual health benefit
23 plan that is not a grandfathered health plan from managing the provision of benefits through com-
24 mon methods, including but not limited to selectively contracted panels, health plan benefit differ-
25 ential designs, preadmission screening, prior authorization of services, utilization review or other
26 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section
27 **provided such methods comply with the requirements of this section.**

28 (4) The Legislative Assembly finds that health care cost containment is necessary and intends
29 to encourage health insurance plans designed to achieve cost containment by ensuring that re-
30 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-
31 ther directly or by reference, **in accordance with this section.**

32 (5) **To ensure the proper use of any medical necessity, utilization or other clinical review**
33 **conducted for the diagnosis, prevention or treatment of behavioral health conditions or re-**
34 **lating to service intensity, level of care placement, continued stay or discharge, a group**
35 **health insurer or an issuer of an individual health benefit plan shall provide, at no cost:**

36 (a) **A formal education program, presented by nonprofit clinical specialty associations or**
37 **other entities authorized by the department, to educate the insurer's or the issuer's staff**
38 **and any individuals described in subsection (2)(k) of this section who conduct reviews.**

39 (b) **To stakeholders, including participating providers and insureds, the medical necessity,**
40 **utilization or other clinical review criteria and any education or training materials or re-**
41 **sources regarding medical necessity, utilization or other clinical review criteria, to the ex-**
42 **tent permitted by copyright laws.**

43 [(5)] (6) This section does not prevent a group health insurer or issuer of an individual health
44 benefit plan that is not a grandfathered health plan from contracting with providers of health care
45 services to furnish services to policyholders or certificate holders according to ORS 743B.460 or

1 750.005, subject to the following conditions:

2 (a) A group health insurer or issuer of an individual health benefit plan that is not a grandfa-
3 thered health plan is not required to contract with all providers that are eligible for reimbursement
4 under this section.

5 (b) An insurer or health care service contractor shall, subject to subsection (2) of this section,
6 pay benefits toward the covered charges of noncontracting providers of services for *[the]* **behavioral**
7 **health** treatment *[of chemical dependency or mental or nervous conditions]*. The insured shall, subject
8 to subsection (2) of this section, have the right to use the services of a noncontracting provider of
9 *[services for the]* **behavioral health** treatment *[of chemical dependency or mental or nervous condi-*
10 *tions]*, whether or not the *[services for chemical dependency or mental or nervous conditions are]* **be-**
11 **havioral health treatment is** provided by contracting or noncontracting providers.

12 [(6)(a)] (7)(a) This section does not require coverage for:

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

15 (B) A long-term residential mental health program that lasts longer than 45 days **unless clin-**
16 **ically indicated under any medical necessity, utilization or other clinical review conducted**
17 **by the insurer for the diagnosis, prevention or treatment of behavioral health conditions or**
18 **relating to service intensity, level of care placement, continued stay or discharge;**

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

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

22 (E) Support groups.

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

26 [(7)] (8) The Oregon Health Authority shall establish a process for the certification of an or-
27 ganization described in subsection [(1)(h)(F)] (1)(j)(F) of this section that:

28 (a) Is not otherwise subject to licensing or certification by the authority; and

29 (b) Does not contract with the authority, a subcontractor of the authority or a community
30 mental health program.

31 [(8)] (9) The Oregon Health Authority shall adopt by rule standards for the certification pro-
32 vided under subsection [(7)] (8) of this section to ensure that a certified provider organization offers
33 a distinct and specialized program for the treatment of mental or nervous conditions.

34 [(9)] (10) The Oregon Health Authority may adopt by rule an application fee or a certification
35 fee, or both, to be imposed on any provider organization that applies for certification under sub-
36 section [(7)] (8) of this section. Any fees collected shall be paid into the Oregon Health Authority
37 Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection
38 [(7)] (8) of this section.

39 [(10)] (11) The intent of the Legislative Assembly in adopting this section is to reserve benefits
40 for different types of care to encourage cost effective care and to ensure continuing access to levels
41 of care most appropriate for the insured's condition and progress **in accordance with this**
42 **section**. This section does not prohibit an insurer from requiring a provider organization certified
43 by the Oregon Health Authority under subsection [(7)] (8) of this section to meet the insurer's cre-
44 dentialing requirements as a condition of entering into a contract.

45 [(11)] (12) The Director of the Department of Consumer and Business Services and the Oregon

1 Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this
2 section that are considered necessary for the proper administration of this section. **The director**
3 **shall adopt rules making it a violation of this section for a group health insurer or issuer**
4 **of an individual health benefit plan other than a grandfathered health plan to require pro-**
5 **viders to bill using a specific billing code or to restrict the reimbursement paid for particular**
6 **billing codes other than on the basis of medical necessity.**

7 (13) **This section does not:**

8 (a) **Prohibit an insured from receiving behavioral health treatment from an out-of-**
9 **network provider or prevent an out-of-network behavioral health provider from billing the**
10 **insured for any unreimbursed cost of treatment.**

11 (b) **Prohibit the use of value-based payment methods, including global budgets or**
12 **capitated, bundled, risk-based or other value-based payment methods.**

13 (c) **Require that any value-based payment method reimburse behavioral health services**
14 **based on an equivalent fee-for-service rate.**

15 **SECTION 6.** ORS 743B.505 is amended to read:

16 743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to
17 individuals or to small employers, as defined in ORS 743B.005, through a specified network of health
18 care providers shall:

19 (a) Contract with or employ a network of providers that is sufficient in number, geographic
20 distribution and types of providers to ensure that all covered services under the health benefit plan,
21 including mental health and substance abuse treatment, are accessible to enrollees **for initial and**
22 **follow up appointments** without unreasonable delay.

23 (b)(A) With respect to health benefit plans offered through the health insurance exchange under
24 ORS 741.310, contract with a sufficient number and geographic distribution of essential community
25 providers, where available, to ensure reasonable and timely access to a broad range of essential
26 community providers for low-income, medically underserved individuals in the plan's service area in
27 accordance with the network adequacy standards established by the Department of Consumer and
28 Business Services;

29 (B) If the health benefit plan offered through the health insurance exchange offers a majority
30 of the covered services through physicians employed by the insurer or through a single contracted
31 medical group, have a sufficient number and geographic distribution of employed or contracted
32 providers and hospital facilities to ensure reasonable and timely access for low-income, medically
33 underserved enrollees in the plan's service area, in accordance with network adequacy standards
34 adopted by the Department of Consumer and Business Services; or

35 (C) With respect to health benefit plans offered outside of the health insurance exchange, con-
36 tract with or employ a network of providers that is sufficient in number, geographic distribution and
37 types of providers to ensure access to care by enrollees who reside in locations within the health
38 benefit plan's service area that are designated by the Health Resources and Services Administration
39 of the United States Department of Health and Human Services as health professional shortage
40 areas or low-income zip codes.

41 (c) Annually report to the Department of Consumer and Business Services, in the format pre-
42 scribed by the department, the insurer's [*plan for ensuring that the*] network of providers for each
43 health benefit plan [*meets the requirements of this section*].

44 (2)(a) An insurer may not discriminate with respect to participation under a health benefit plan
45 or coverage under the plan against any health care provider who is acting within the scope of the

1 provider's license or certification in this state.

2 (b) This subsection does not require an insurer to contract with any health care provider who
3 is willing to abide by the insurer's terms and conditions for participation established by the insurer.

4 (c) This subsection does not prevent an insurer from establishing varying reimbursement rates
5 based on quality or performance measures.

6 (d) Rules adopted by the Department of Consumer and Business Services to implement this sec-
7 tion shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United
8 States Department of Health and Human Services, the United States Department of the Treasury
9 or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect on Jan-
10 uary 1, 2017.

11 (3) The Department of Consumer and Business Services shall use one of the following methods
12 in *[evaluating]* **an annual evaluation of** whether the network of providers available to enrollees in
13 a health benefit plan meets the requirements of this section:

14 (a) An approach by which an insurer submits evidence that the insurer is complying with at
15 least one of the factors prescribed by the department by rule from each of the following categories:

16 (A) Access to care consistent with the needs of the enrollees served by the network;

17 (B) Consumer satisfaction;

18 (C) Transparency; and

19 (D) Quality of care and cost containment; or

20 (b) A nationally recognized standard adopted by the department and adjusted, as necessary, to
21 reflect the age demographics of the enrollees in the plan.

22 **(4) In evaluating an insurer's network of mental and behavioral health providers under**
23 **subsection (3) of this section, the department shall ensure that the network includes:**

24 **(a) An adequate number and geographic distribution, as prescribed by the department by**
25 **rule, of licensed professional counselors, licensed marriage and family therapists, licensed**
26 **clinical social workers, psychologists and psychiatrists who are accepting new patients, based**
27 **on the needs of the insureds under the policy or certificate, including but not limited to**
28 **providers who can address the needs of:**

29 **(A) Children and adults;**

30 **(B) Individuals with limited English proficiency or who are illiterate;**

31 **(C) Individuals with diverse cultural or ethnic backgrounds;**

32 **(D) Individuals with chronic or complex behavioral health conditions; and**

33 **(E) Other groups specified by the department by rule; and**

34 **(b) An adequate number of the providers described in paragraph (a) of this subsection in**
35 **all geographic areas where the insurer offers plans.**

36 ~~[(4)]~~ **(5)** This section does not require an insurer to contract with an essential community pro-
37 vider that refuses to accept the insurer's generally applicable payment rates for services covered
38 by the plan.

39 ~~[(5)]~~ **(6)** This section does not require an insurer to submit provider contracts to the department
40 for review.

41 **SECTION 7.** Section 2 of this 2021 Act is amended to read:

42 **Sec. 2.** (1) As used in this section:

43 (a) "Behavioral health benefits" means insurance coverage of mental health treatment and ser-
44 vices and substance use disorder treatment and services.

45 (b) "Carrier" has the meaning given that term in ORS 743B.005.

1 (c) "Geographic region" means the geographic area of the state established by the Department
2 of Consumer and Business Services for the purpose of determining geographic average rates, as de-
3 fined in ORS 743B.005.

4 (d) "Health benefit plan" has the meaning given that term in ORS 743B.005.

5 (e) "Median maximum allowable reimbursement rate" means the median of all maximum allow-
6 able reimbursement rates, minus incentive payments, paid for each billing code for each provider
7 type during a calendar year.

8 (f) "Mental health treatment and services" means the treatment of or services provided to ad-
9 dress any condition or disorder that falls under any of the diagnostic categories listed in the mental
10 disorders section of the current edition of the:

11 (A) International Classification of Disease; or

12 (B) Diagnostic and Statistical Manual of Mental Disorders.

13 (g) "Nonquantitative treatment limitation" means a limitation that is not expressed numerically
14 but otherwise limits the scope or duration of behavioral health benefits.

15 (h) "Substance use disorder treatment and services" means the treatment of or services provided
16 to address any condition or disorder that falls under any of the diagnostic categories listed in the
17 substance use section of the current edition of the:

18 (A) International Classification of Disease; or

19 (B) Diagnostic and Statistical Manual of Mental Disorders.

20 (2) Each carrier that offers an individual or group health benefit plan in this state that provides
21 behavioral health benefits shall conduct an annual analysis of whether the processes, strategies,
22 specific evidentiary standards or other factors the carrier used to design, determine applicability of
23 and apply each nonquantitative treatment limitation to behavioral health benefits within each clas-
24 sification of benefits are comparable to, and are applied no more stringently than, the processes,
25 strategies, specific evidentiary standards or other factors the carrier used to design, determine ap-
26 plicability of and apply each nonquantitative treatment limitation to medical and surgical benefits
27 within the corresponding classification of benefits.

28 (3) On or before March 1 of each year, all carriers that offer individual or group health benefit
29 plans in this state that provide behavioral health benefits shall report to the Department of Con-
30 sumer and Business Services, in the form and manner prescribed by the department, the following
31 information:

32 (a) The specific plan or coverage terms or other relevant terms regarding the nonquantitative
33 treatment limitations and a description of all mental health or substance use disorder and medical
34 or surgical benefits to which each such term applies in each respective benefits classification.

35 (b) The factors used to determine that the nonquantitative treatment limitations will apply to
36 mental health or substance use disorder benefits and medical or surgical benefits.

37 (c) The evidentiary standards used for the factors identified in paragraph (b) of this subsection,
38 when applicable, provided that every factor is defined, and any other source or evidence relied upon
39 to design and apply the nonquantitative treatment limitations to mental health or substance use
40 disorder benefits and medical or surgical benefits.

41 (d) The comparative analyses demonstrating that the processes, strategies, evidentiary standards
42 and other factors used to apply the nonquantitative treatment limitations to mental health or sub-
43 stance use disorder benefits, as written and in operation, are comparable to, and are applied no more
44 stringently than, the processes, strategies, evidentiary standards and other factors used to apply the
45 nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.

1 (e) The specific findings and conclusions reached by the insurer with respect to the health in-
2 surance coverage, including any results of the analyses described in paragraphs (a) to (d) of this
3 subsection that indicate that the plan or coverage is or is not in compliance with this section.

4 [(f) *The number of denials of behavioral health benefits and medical and surgical benefits, the*
5 *percentage of denials that were appealed, the percentage of appeals that upheld the denial and the*
6 *percentage of appeals that overturned the denial.*]

7 [(g) *The percentage of claims for behavioral health benefits and medical and surgical benefits that*
8 *were paid to in-network providers and the percentage of such claims that were paid to out-of-network*
9 *providers.*]

10 [(h) *The median maximum allowable reimbursement rate for each time-based office visit billing code*
11 *for each behavioral treatment provider type and each medical provider type.*]

12 [(i) *The reimbursement rate in each geographic region for a time-based office visit and the per-*
13 *centage of the Medicare rate the reimbursement rate represents, paid to:*]

14 [(A) *Psychiatrists.*]

15 [(B) *Psychiatric mental health nurse practitioners.*]

16 [(C) *Psychologists.*]

17 [(D) *Licensed clinical social workers.*]

18 [(E) *Licensed professional counselors.*]

19 [(F) *Licensed marriage and family therapists.*]

20 [(j) *The reimbursement rate in each geographic region for a time-based office visit and the per-*
21 *centage of the Medicare rate the reimbursement rate represents, paid to:*]

22 [(A) *Physicians.*]

23 [(B) *Physician assistants.*]

24 [(C) *Licensed nurse practitioners.*]

25 [(k) *The specific findings and conclusions of the carrier under subsection (2) of this section dem-*
26 *onstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health*
27 *Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.*]

28 [(L)] (f) Other data or information the department deems necessary to assess a carrier's com-
29 pliance with mental health parity requirements.

30 (4) No later than September 15 of each calendar year, the department shall report to the interim
31 committees of the Legislative Assembly related to mental or behavioral health, in the manner pro-
32 vided in ORS 192.245, the information reported under subsection (3) of this section, including the
33 department's overall comparison of carriers' coverage of mental health treatment and services and
34 substance use disorder treatment and services to carriers' coverage of medical or surgical treat-
35 ments or services.

36 **SECTION 8.** ORS 743A.168, as amended by section 5 of this 2021 Act, is amended to read:

37 743A.168. (1) As used in this section:

38 (a) "Behavioral health assessment" means an evaluation by a provider, in person or using tele-
39 medicine, to determine a patient's need for behavioral health treatment.

40 (b) "Behavioral health condition" has the meaning prescribed by rule by the Department of
41 Consumer and Business Services.

42 (c) "Behavioral health crisis" means a disruption in an insured's mental or emotional stability
43 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-
44 partment or admission to a hospital to prevent a serious deterioration in the insured's mental or
45 physical health.

1 (d) "Facility" means a corporate or governmental entity or other provider of services for the
2 treatment of behavioral health conditions.

3 (e) "Generally accepted standards of care" means:

4 (A) Standards of care and clinical practice guidelines that:

5 (i) Are generally recognized by health care providers practicing in relevant clinical specialties;
6 and

7 (ii) Are based on valid, evidence-based sources; and

8 (B) Products and services that:

9 (i) Address the specific needs of a patient for the purpose of screening for, preventing, diagnos-
10 ing, managing or treating an illness, injury or condition or symptoms of an illness, injury or condi-
11 tion;

12 (ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and

13 (iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience
14 of a patient, treating physician or other health care provider.

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

17 (g) "Median maximum allowable reimbursement rate" means the median of all maximum allow-
18 able reimbursement rates, minus incentive payments, paid for each billing code for each provider
19 type during a calendar year.

20 (h) "Prior authorization" has the meaning given that term in ORS 743B.001.

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

23 (j) "Provider" means:

24 (A) A behavioral health professional or medical professional licensed or certified in this state
25 who has met the credentialing requirement of a group health insurer or an issuer of an individual
26 health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is oth-
27 erwise eligible to receive reimbursement for coverage under the policy;

28 (B) A health care facility as defined in ORS 433.060;

29 (C) A residential facility as defined in ORS 430.010;

30 (D) A day or partial hospitalization program;

31 (E) An outpatient service as defined in ORS 430.010; or

32 (F) A provider organization certified by the Oregon Health Authority under subsection [(8)] (9)
33 of this section.

34 (k) "Relevant clinical specialties" includes but is not limited to:

35 (A) Psychiatry;

36 (B) Psychology;

37 (C) Clinical sociology;

38 (D) Addiction medicine and counseling; and

39 (E) Behavioral health treatment.

40 (L) "Standards of care and clinical practice guidelines" includes but is not limited to:

41 (A) Patient placement criteria;

42 (B) Recommendations of agencies of the federal government; and

43 (C) Drug labeling approved by the United States Food and Drug Administration.

44 (m) "Utilization review" has the meaning given that term in ORS 743B.001.

45 (n) "Valid, evidence-based sources" includes but is not limited to:

- 1 (A) Peer-reviewed scientific studies and medical literature;
- 2 (B) Recommendations of nonprofit health care provider professional associations; and
- 3 (C) Specialty societies.

4 (2) A group health insurance policy or an individual health benefit plan that is not a grandfa-
5 thered health plan providing coverage for hospital or medical expenses, other than limited benefit
6 coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health con-
7 ditions and medically necessary behavioral health treatment at the same level as, and subject to
8 limitations no more restrictive than, those imposed on coverage or reimbursement of expenses aris-
9 ing from treatment for other medical conditions. The following apply to coverage for behavioral
10 health treatment:

11 (a) The coverage may be made subject to provisions of the policy that apply to other benefits
12 under the policy, including but not limited to provisions relating to copayments, deductibles and
13 coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or
14 residential facilities may not be greater than those under the policy for expenses of hospitalization
15 in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpa-
16 tient treatment may not be greater than those under the policy for expenses of outpatient treatment
17 of other medical conditions.

18 (b) The coverage of behavioral health treatment may not be made subject to treatment limita-
19 tions, limits on total payments for treatment, limits on duration of treatment or financial require-
20 ments unless similar limitations or requirements are imposed on coverage of other medical
21 conditions. The coverage of eligible expenses of behavioral health treatment may be limited to
22 treatment that is medically necessary as determined in accordance with this section and no more
23 stringently under the policy than for other medical conditions.

24 (c) The coverage of behavioral health treatment must include:

25 (A) A behavioral health assessment;

26 (B) No less than the level of services determined to be medically necessary in a behavioral
27 health assessment of the specific needs of a patient or in a patient's care plan:

28 (i) To effectively treat the patient's underlying behavioral health condition rather than the mere
29 amelioration of current symptoms such as suicidal ideation or psychosis; and

30 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of
31 care;

32 (C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordi-
33 nated manner;

34 (D) Treatment at the least intensive and least restrictive level of care that is safe and most ef-
35 fective and meets the needs of the insured's condition;

36 (E) A lower level or less intensive care only if it is comparably as safe and effective as treat-
37 ment at a higher level of service or intensity;

38 (F) Treatment to maintain functioning or prevent deterioration;

39 (G) Treatment for an appropriate duration based on the insured's particular needs;

40 (H) Treatment appropriate to the unique needs of children and adolescents;

41 (I) Treatment appropriate to the unique needs of older adults; and

42 (J) Coordinated care and case management as defined by the Department of Consumer and
43 Business Services by rule.

44 (d) The coverage of behavioral health treatment may not limit coverage for treatment of perva-
45 sive or chronic behavioral health conditions to short-term or acute behavioral health treatment at

1 any level of care or placement.

2 (e) A group health insurer or an issuer of an individual health benefit plan other than a grand-
3 fathered health plan shall have a network of providers of behavioral health treatment sufficient to
4 meet the standards described in ORS 743B.505. If there is no in-network provider qualified to timely
5 deliver, as defined by rule, medically necessary behavioral treatment to an insured in a geographic
6 area, the group health insurer or issuer of an individual health benefit plan shall provide coverage
7 of out-of-network medically necessary behavioral health treatment without any additional out-of-
8 pocket costs if provided by an available out-of-network provider that enters into an agreement with
9 the insurer to be reimbursed at in-network rates.

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

11 (A) The provider is approved or certified by the Oregon Health Authority;

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

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

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

17 (g) A group health insurer or an issuer of an individual health benefit plan other than a grand-
18 fathered health plan must use the same methodology to set reimbursement rates paid to behavioral
19 health treatment providers that the group health insurer or issuer of an individual health benefit
20 plan uses to set reimbursement rates for medical and surgical treatment providers.

21 (h) A group health insurer or an issuer of an individual health benefit plan other than a
22 grandfathered health plan must update the methodology and rates for reimbursing behavioral health
23 treatment providers in a manner equivalent to the manner in which the group health insurer or
24 issuer of an individual health benefit plan updates the methodology and rates for reimbursing med-
25 ical and surgical treatment providers, unless otherwise required by federal law.

26 (i) A group health insurer or an issuer of an individual health benefit plan other than a grand-
27 fathered health plan that reimburses out-of-network providers for medical or surgical services must
28 reimburse out-of-network behavioral health treatment providers on the same terms and at a rate that
29 is in parity with the rate paid to medical or surgical treatment providers.

30 (j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service
31 or outpatient services if clinically indicated under [*any medical necessity, utilization or other clinical*
32 *review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating*
33 *to service intensity, level of care placement, continued stay or discharge*] **criteria and guidelines de-**
34 **scribed in subsection (5) of this section.** The policy may limit coverage for in-home service to
35 persons who are homebound under the care of a physician only if clinically indicated under [*any*
36 *medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treat-*
37 *ment of behavioral health conditions or relating to service intensity, level of care placement, continued*
38 *stay or discharge*] **criteria and guidelines described in subsection (5) of this section.**

39 (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-
40 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250
41 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-
42 sional counselors and licensed marriage and family therapists, a group health insurer or issuer of
43 an individual health benefit plan may provide for review for level of treatment of admissions and
44 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization
45 programs and outpatient services by either staff of a group health insurer or issuer of an individual

1 health benefit plan or personnel under contract to the group health insurer or issuer of an individual
2 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,
3 who shall have the authority to certify for or deny level of payment.

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

6 (C) Review shall be performed by or under the direction of a physician licensed under ORS
7 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social
8 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-
9 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and
10 Therapists, in accordance with standards of the National Committee for Quality Assurance or
11 Medicare review standards of the Centers for Medicare and Medicaid Services.

12 (D) Review may involve prior approval, concurrent review of the continuation of treatment,
13 post-treatment review or any combination of these. However, if prior approval is required, provision
14 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-
15 view. If prior approval is not required, group health insurers and issuers of individual health benefit
16 plans that are not grandfathered health plans shall permit providers, policyholders or persons acting
17 on their behalf to make advance inquiries regarding the appropriateness of a particular admission
18 to a treatment program. Group health insurers and issuers of individual health benefit plans that
19 are not grandfathered health plans shall provide a timely response to such inquiries. Noncontracting
20 providers must cooperate with these procedures to the same extent as contracting providers to be
21 eligible for reimbursement.

22 (L) Health maintenance organizations may limit the receipt of covered services by enrollees to
23 services provided by or upon referral by providers contracting with the health maintenance organ-
24 ization. Health maintenance organizations and health care service contractors may create substan-
25 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no
26 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other
27 medical conditions and apply them to contracting and noncontracting providers.

28 (3) This section does not prohibit a group health insurer or issuer of an individual health benefit
29 plan that is not a grandfathered health plan from managing the provision of benefits through com-
30 mon methods, including but not limited to selectively contracted panels, health plan benefit differ-
31 ential designs, preadmission screening, prior authorization of services, utilization review or other
32 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section
33 provided such methods comply with the requirements of this section.

34 (4) The Legislative Assembly finds that health care cost containment is necessary and intends
35 to encourage health insurance plans designed to achieve cost containment by ensuring that re-
36 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-
37 ther directly or by reference, in accordance with this section.

38 **(5)(a) Any medical necessity, utilization or other clinical review conducted for the diag-**
39 **nosis, prevention or treatment of behavioral health conditions or relating to service inten-**
40 **sity, level of care placement, continued stay or discharge must be based solely on the**
41 **following:**

42 **(A) The current generally accepted standards of care.**

43 **(B) For level of care placement decisions, the most recent version of the levels of care**
44 **placement criteria developed by the nonprofit professional association for the relevant clin-**
45 **ical specialty.**

1 (C) For medical necessity, utilization or other clinical review conducted for the diagnosis,
2 prevention or treatment of behavioral health conditions that does not involve level of care
3 placement decisions, other criteria and guidelines may be utilized if such criteria and guide-
4 lines are based on the current generally accepted standards of care including valid,
5 evidence-based sources and current treatment criteria or practice guidelines developed by
6 the nonprofit professional association for the relevant clinical specialty. Such other criteria
7 and guidelines must be made publicly available and made available to insureds upon request
8 to the extent permitted by copyright laws.

9 (b) This subsection does not prevent a group health insurer or an issuer of an individual
10 health benefit plan other than a grandfathered health plan from using criteria that:

11 (A) Are outside the scope of criteria and guidelines described in paragraph (a)(B) of this
12 subsection, if the guidelines were developed in accordance with the current generally ac-
13 cepted standards of care; or

14 (B) Are based on advancements in technology of types of care that are not addressed in
15 the most recent versions of sources specified in paragraph (a)(B) of this subsection, if the
16 guidelines were developed in accordance with current generally accepted standards of care.

17 (c) For all level of care placement decisions, an insurer shall authorize placement at the
18 level of care consistent with the insured's score or assessment using the relevant level of
19 care placement criteria and guidelines as specified in paragraph (a)(B) of this subsection. If
20 the level of care indicated by the criteria and guidelines is not available, the insurer shall
21 authorize the next higher level of care. If there is disagreement about the appropriate level
22 of care, the insurer shall provide to the provider of the service the full details of the
23 insurer's scoring or assessment using the relevant level of care placement criteria and
24 guidelines specified in paragraph (a)(B) of this subsection.

25 [(5)] (6) To ensure the proper use of any [*medical necessity, utilization or other clinical review*
26 *conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to ser-*
27 *vice intensity, level of care placement, continued stay or discharge*] **criteria and guidelines described**
28 **in subsection (5) of this section**, a group health insurer or an issuer of an individual health benefit
29 plan shall provide, at no cost:

30 (a) A formal education program, presented by nonprofit clinical specialty associations or other
31 entities authorized by the department, to educate the insurer's or the issuer's staff and any individ-
32 uals described in subsection (2)(k) of this section who conduct reviews.

33 (b) To stakeholders, including participating providers and insureds, the [*medical necessity, utili-*
34 *zation or other clinical review criteria*] **criteria and guidelines described in subsection (5) of this**
35 **section** and any education or training materials or resources regarding [*medical necessity, utilization*
36 *or other clinical review criteria, to the extent permitted by copyright laws*] **the criteria and**
37 **guidelines**.

38 [(6)] (7) This section does not prevent a group health insurer or issuer of an individual health
39 benefit plan that is not a grandfathered health plan from contracting with providers of health care
40 services to furnish services to policyholders or certificate holders according to ORS 743B.460 or
41 750.005, subject to the following conditions:

42 (a) A group health insurer or issuer of an individual health benefit plan that is not a grandfa-
43 thered health plan is not required to contract with all providers that are eligible for reimbursement
44 under this section.

45 (b) An insurer or health care service contractor shall, subject to subsection (2) of this section,

1 pay benefits toward the covered charges of noncontracting providers of services for behavioral
2 health treatment. The insured shall, subject to subsection (2) of this section, have the right to use
3 the services of a noncontracting provider of behavioral health treatment, whether or not the be-
4 havioral health treatment is provided by contracting or noncontracting providers.

5 [(7)(a)] **(8)(a)** This section does not require coverage for:

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

8 (B) A long-term residential mental health program that lasts longer than 45 days unless clin-
9 ically indicated under *[any medical necessity, utilization or other clinical review conducted by the*
10 *insurer for the diagnosis, prevention or treatment of behavioral health conditions or relating to service*
11 *intensity, level of care placement, continued stay or discharge]* **criteria and guidelines described in**
12 **subsection (5) of this section;**

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

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

16 (E) Support groups.

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

20 [(8)] **(9)** The Oregon Health Authority shall establish a process for the certification of an or-
21 ganization described in subsection (1)(j)(F) of this section that:

22 (a) Is not otherwise subject to licensing or certification by the authority; and

23 (b) Does not contract with the authority, a subcontractor of the authority or a community
24 mental health program.

25 [(9)] **(10)** The Oregon Health Authority shall adopt by rule standards for the certification pro-
26 vided under subsection [(8)] **(9)** of this section to ensure that a certified provider organization offers
27 a distinct and specialized program for the treatment of mental or nervous conditions.

28 [(10)] **(11)** The Oregon Health Authority may adopt by rule an application fee or a certification
29 fee, or both, to be imposed on any provider organization that applies for certification under sub-
30 section [(8)] **(9)** of this section. Any fees collected shall be paid into the Oregon Health Authority
31 Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection
32 [(8)] **(9)** of this section.

33 [(11)] **(12)** The intent of the Legislative Assembly in adopting this section is to reserve benefits
34 for different types of care to encourage cost effective care and to ensure continuing access to levels
35 of care most appropriate for the insured's condition and progress in accordance with this section.
36 This section does not prohibit an insurer from requiring a provider organization certified by the
37 Oregon Health Authority under subsection [(8)] **(9)** of this section to meet the insurer's credentialing
38 requirements as a condition of entering into a contract.

39 [(12)] **(13)** The Director of the Department of Consumer and Business Services and the Oregon
40 Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this
41 section that are considered necessary for the proper administration of this section. The director
42 shall adopt rules making it a violation of this section for a group health insurer or issuer of an in-
43 dividual health benefit plan other than a grandfathered health plan to require providers to bill using
44 a specific billing code or to restrict the reimbursement paid for particular billing codes other than
45 on the basis of medical necessity.

1 [(13)] (14) This section does not:

2 (a) Prohibit an insured from receiving behavioral health treatment from an out-of-network pro-
3 vider or prevent an out-of-network behavioral health provider from billing the insured for any un-
4 reimbursed cost of treatment.

5 (b) Prohibit the use of value-based payment methods, including global budgets or capitated,
6 bundled, risk-based or other value-based payment methods.

7 (c) Require that any value-based payment method reimburse behavioral health services based
8 on an equivalent fee-for-service rate.

9 **SECTION 9. (1) The amendments to section 2 of this 2021 Act by section 7 of this 2021**
10 **Act become operative on January 1, 2025.**

11 **(2) The amendments to ORS 743A.168 by section 8 of this 2021 Act become operative on**
12 **January 1, 2023.**

13 **SECTION 10. Notwithstanding any other law limiting expenditures, the limitation on**
14 **expenditures established by section 1 (6), chapter _____, Oregon Laws 2021 (Enrolled Sen-**
15 **ate Bill 5510), for the biennium beginning July 1, 2021, as the maximum limit for payment**
16 **of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but ex-**
17 **cluding lottery funds and federal funds, collected or received by the Department of Consumer**
18 **and Business Services for the Division of Financial Regulation, is increased by \$708,708 for**
19 **the purpose of carrying out the provisions of this 2021 Act.**

20