House Bill 3725

Sponsored by Representative NOSSE

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.** The statement includes a measure digest written in compliance with applicable readability standards.

Digest: This Act makes changes to the claims process for health care providers and insurers and makes changes to the rules for reports, utilization review and information that must be given by some carriers for behavioral health care services. This Act also adds a new member to the HIEAC. This Act creates a new ombudsman. This Act makes it an emergency. (Flesch Readability Score: 61.8).

Modifies requirements for certain claims processes for health care providers and insurers.

Modifies requirements for utilization review for behavioral health care providers. Adds information carriers that provide behavioral health benefits must report to the Department of Consumer and Business Services in the yearly report. Establishes certain information these carriers that conduct medical management techniques must provide to behavioral health care providers in writing. Adds a representative of behavioral health care providers as one of the members who must be appointed to the Health Insurance Exchange Advisory Committee.

Establishes the Mental Health Parity Ombudsman in the Department of Consumer and Business Services and appropriates moneys to the department.

Declares an emergency, effective on passage.

A BILL FOR AN ACT

Relating to health care; creating new provisions, amending ORS 741.004, 743A.168, 743B.427 and 743B.451; and declaring an emergency.

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

CLAIMS PROCESS

SECTION 1. ORS 743B.451 is amended to read:

743B.451. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(2) Except in the case of fraud or abuse of billing, and except as provided in subsections (3) and (5) of this section, a health insurer may not:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing on or before the last day of the period specified by the contract with the health care provider or 18 months after the date the payment was made, whichever is earlier; and

(B) Specifies in the written request why the health insurer believes the provider owes the refund.

(b) Request that a contested refund be paid earlier than six months after the health care provider receives the request.

(3) A health insurer may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

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.

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 30 months after the date the payment was made;

(B) Specifies in the written request why the health insurer believes the provider owes the refund; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has primary responsibility for payment of the claim.

(b) Request that a contested refund be paid earlier than six months after the provider receives the request.

[*(4) If a health care provider fails to contest a refund request in writing to the health insurer within 30 days after receiving the request, the request is deemed accepted and the provider must pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the refund within 30 days after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.*]

(4) A health care provider must contest a refund request to a health insurer in writing within six months after receiving the request. The health insurer shall respond to the health care provider that has contested a refund request or, if a written request to contest the refund is not received within six months after the health care provider received the refund request, the health insurer shall notify the health care provider that the refund request has been deemed accepted. If a refund request is deemed accepted, the health care provider must pay the refund within six months after the request is deemed accepted. A health insurer may not electronically withdraw funds directly from a health care provider's bank account for refund requests, including refund requests that are deemed accepted. If the provider has not paid the refund within six months after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.

(5) A health insurer may at any time request from a health care provider a refund of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and

(b) The health insurer is unable to recover directly from the third party because the third party has already paid or will pay the provider for the health care services covered by the claim.

(6) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a health insurer any payment previously made to satisfy a claim.

(7) This section neither permits nor precludes a health insurer from recovering from a subscriber, enrollee or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy or other benefit agreement.

(8) This section applies to health benefit plans.

SECTION 1a. The amendments to ORS 743B.451 by section 1 of this 2025 Act apply to refund requests sent to health care providers on or after the effective date of this 2025 Act.

BEHAVIORAL HEALTH CARE

SECTION 2. ORS 743A.168, as amended by section 3, chapter 70, Oregon Laws 2024, is amended to read:

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

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

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

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

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

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

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

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

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

(B) Products and services that:

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

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

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

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

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

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

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

(j) "Provider" means:

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

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

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

(D) A day or partial hospitalization program;

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

(F) A provider organization certified by the Oregon Health Authority under subsection (9) of this section.

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

(A) Psychiatry;

(B) Psychology;

(C) Clinical sociology;

(D) Addiction medicine and counseling; and

(E) Behavioral health treatment.

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

(A) Patient placement criteria;

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

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

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

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

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

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

(C) Specialty societies.

(2) A group health insurance policy or an individual health benefit plan that is not a grandfathered health plan providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for behavioral health treatment:

(a) 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 copayments, deductibles and coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(b) The coverage of behavioral health treatment 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 of behavioral health treatment may be limited to treatment that is medically necessary as determined in accordance with this section and no more stringently under the policy than for other medical conditions.

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

(A) A behavioral health assessment;

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

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

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

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

(D) Treatment at the least intensive and least restrictive level of care that is safe and most ef-

fective and meets the needs of the insured's condition;

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

(F) Treatment to maintain functioning or prevent deterioration;

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

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

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

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

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

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

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

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

(B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission 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.

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

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

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

(j) Outpatient coverage of behavioral health treatment shall include follow-up in-home service or outpatient services if clinically indicated under criteria and guidelines described in subsection (5) of this section. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician only if clinically indicated under criteria and guidelines described in subsection (5) of this section.

(k)(A) Subject to section 2, chapter 70, Oregon Laws 2024, and 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 or issuer of an individual health benefit plan may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, 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 physician licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, 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 authorization, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior authorization is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior authorization is not required, group health insurers and issuers of individual health benefit plans that are not grandfathered health plans 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 and issuers of individual health benefit plans that are not grandfathered health plans 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.

(L) 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.

(3) Except as provided in section 2, chapter 70, Oregon Laws 2024, this section does not prohibit a group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan 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 (2)(b) of this section provided such methods comply with the requirements of this section.

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-

ther directly or by reference, in accordance with this section.

(5)(a) Any medical necessity, utilization or other clinical review conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to service intensity, level of care placement, continued stay or discharge must be based solely on the following:

(A) The current generally accepted standards of care.

(B) For level of care placement decisions, the most recent version of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.

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

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

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

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

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

(6) To ensure the proper use of any criteria and guidelines described in subsection (5) of this section, a group health insurer or an issuer of an individual health benefit plan shall provide, at no cost:

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

(b) To stakeholders, including participating providers and insureds, the criteria and guidelines described in subsection (5) of this section and any education or training materials or resources regarding the criteria and guidelines.

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

(a) A group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan is not required to contract with all providers that are eligible for reimbursement

under this section.

(b) An insurer or health care service contractor shall, subject to subsection (2) of this section, pay benefits toward the covered charges of noncontracting providers of services for behavioral health treatment. The insured shall, subject to subsection (2) of this section, have the right to use the services of a noncontracting provider of behavioral health treatment, whether or not the behavioral health treatment is provided by contracting or noncontracting providers.

(8)(a) This section does not require 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 unless clinically indicated under criteria and guidelines described in subsection (5) of this section;

(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) 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.

(9) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(j)(F) of this section that:

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

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

(10) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (9) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

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

(12) 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 in accordance with this section. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (9) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

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

(14) This section does not:

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

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

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

SECTION 3. ORS 743B.427, as amended by section 7, chapter 629, Oregon Laws 2021, and sections 157 and 157a, chapter 73, Oregon Laws 2024, is amended to read:

743B.427. (1) As used in this section:

(a) "Behavioral health benefits" means insurance coverage of mental health treatment and services and substance use disorder treatment and services.

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

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

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

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

(f) "Medical management techniques" includes audits, prepayment reviews, post-payment reviews, clinical reviews, utilization reviews, risk adjustment reviews, utilization monitoring of specific billing codes, denial of claims and recoupment of paid claims.

[*(f)*] **(g)** "Mental health treatment and services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(h) "Nonqualitative treatment limitations" includes medical management techniques if the medical management technique limits the scope or duration of treatment.

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

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

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

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

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

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

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

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

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

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

(f) The number of denials of behavioral health benefits and medical and surgical benefits, the percentage of denials that were appealed and the percentage of appeals that overturned the denial.

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

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

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

(A) Psychiatrists.

(B) Psychiatric mental health and nurse practitioners.

(C) Psychologists.

(D) Licensed and clinical social works.

(E) Licensed professional counselors.

(F) Licensed marriage and family therapists.

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

(A) Physicians.

(B) Physician associates.

(C) Licensed nurse practitioners.

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

thereunder.

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

(4) Each carrier that offers an individual or group health benefit plan in this state that provides behavioral health benefits and conducts medical management techniques shall provide to the behavioral health provider in writing:

(a) The type and purpose of the medical management technique;

(b) The basis for selecting the provider for review;

(c) The corresponding nonqualitative treatment limitation that the insurer or carrier would apply to a medical or surgical provider in the same situation;

(d) A reference to the specific statute that is the basis for the review; and

(e) An attestation that the medical management technique utilized is being applied with the same frequency to a medical or surgical classification of benefits as described by ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

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

SECTION 4. ORS 741.004 is amended to read:

741.004. (1) The Health Insurance Exchange Advisory Committee is created to advise the Oregon Health Policy Board in the development and implementation of the policies and operational procedures governing the administration of a health insurance exchange in this state including, but not limited to, all of the following:

(a) The amount of the assessment imposed on insurers under ORS 741.105.

(b) The operation of a Small Business Health Options Program in accordance with 42 U.S.C. 18031.

(c) The processes and procedures to enable each insurance producer to be authorized to act for all of the insurers offering qualified health plans through the health insurance exchange.

(d) The affordability of qualified health plans offered by employers under section 5000A(e)(1) of the Internal Revenue Code.

(e) Outreach strategies for reaching minority and low-income communities.

(f) Solicitation of customer feedback.

(g) The affordability of health plans offered through the exchange.

(2) The committee consists of 15 members. Thirteen members shall be appointed by the Governor and are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565. The appointed members serve at the pleasure of the Governor. The Director of the Oregon Health Authority or the director's designee and the Director of the Department of Consumer and Business Services or the director's designee shall serve as ex officio members of the committee.

(3) The 13 members appointed by the Governor must represent the interests of:

(a) Insurers;

(b) Insurance producers;

(c) Navigators, in-person assisters, application counselors and other individuals with experience

in facilitating enrollment in qualified health plans;

(d) Health care providers;

(e) The business community, including small businesses and self-employed individuals;

(f) Consumer advocacy groups, including advocates for enrolling hard-to-reach populations;

(g) Enrollees in qualified health plans; [*and*]

(h) State agencies that administer the medical assistance program under ORS chapter 414**; and**

(i) Behavioral health care providers.

(4) The Oregon Health Policy Board or the Director of the Oregon Health Authority may solicit recommendations from the committee and the committee may initiate recommendations on its own.

(5) The committee may provide annual reports to the Legislative Assembly, in the manner provided in ORS 192.245, of the findings and recommendations the committee considers appropriate, including but not limited to a report on the:

(a) Adequacy of assessments for reserve programs and administrative costs;

(b) Operation of the Small Business Health Options Program;

(c) Number of qualified health plans offered through the exchange;

(d) Number and demographics of individuals enrolled in qualified health plans;

(e) Advance premium tax credits provided to enrollees in qualified health plans; and

(f) Feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange.

(6) The members of the committee shall be appointed for a term fixed by the Governor, not to exceed two years, and shall serve without compensation, but shall be entitled to travel expenses in accordance with ORS 292.495. The committee may hire, subject to the approval of the director, such experts as the committee may require to discharge its duties. All expenses of the committee shall be paid out of the Health Insurance Exchange Fund established in ORS 741.102.

(7) The employees of the Oregon Health Authority responsible for administering the health insurance exchange are directed to assist the committee in the performance of its duties under subsection (1) of this section and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committee consider necessary to perform their duties under subsection (1) of this section.

MENTAL HEALTH PARITY OMBUDSMAN

SECTION 5. As used in sections 6 and 7 of this 2025 Act:

(1) "Mental health parity" means the insurance coverage for mental health and substance abuse disorders are the same as coverage for other health conditions as described in ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

(2) "Provider" has the meaning given that term in ORS 743A.168.

SECTION 6. (1) The office of the Mental Health Parity Ombudsman is established. The Mental Health Parity Ombudsman shall function separately and independently from any other state agency. The Director of the Department of Consumer and Business Services, with the concurrence of the Governor, shall appoint the Mental Health Parity Ombudsman. The ombudsman is under the supervision and control of the director and, with the concurrence of the Governor, the director may terminate the ombudsman.

(2) The Mental Health Parity Ombudsman shall have background and experience in the

following areas:

(a) The fields of mental health or substance abuse disorder;

(b) Behavioral health care;

(c) Working with community programs;

(d) Strong understanding of behavioral health care and substance abuse disorder, both regulatory and policy;

(e) Working with providers and health insurers;

(f) Working with and involvement in volunteer programs; and

(g) Administrative and managerial experience.

(3) The Mental Health Parity Ombudsman shall:

(a) Advocate for beneficiaries and providers of behavioral health services by accepting, investigating and attempting to resolve complaints concerning violations of ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

(b) Provide information to beneficiaries of behavioral health services to enable them to access their rights to receive health insurance coverage for behavioral health services in parity with medical surgical services.

(c) Provide public education and outreach on the mental health parity requirements, including information on how to identify a compliance issue.

(d) Provide information and assistance to behavioral health providers who are in dispute with insurers with regard to state and federal mental health parity laws, including access to the required non-qualititative treatment limitations comparative analyses and navigating the appeals processes for denials and repayment requests by insurers.

(e) Report to the Governor and director in writing at least once each quarter. A report shall include a summary of consumer and provider complaints and identified mental health parity deficiencies by insurers during the quarter, a summary of the services that the ombudsman provided during the quarter, and the ombudsman's recommendations for improving ombudsman services and recommendations for administration of ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

(f) Adopt rules necessary for carrying out the requirements of this section and section 7 of this 2025 Act.

(4) The Mental Health Parity Ombudsman may hire up to five deputy ombudsmen as necessary to perform the duties of the ombudsman.

SECTION 7. The Mental Health Parity Ombudsman shall establish procedures to maintain the confidentiality of the records and files of individuals who file a complaint with the ombudsman. These procedures must meet the following requirements:

(1) The ombudsman or a designee may not disclose the identity of any complainant unless the complainant or the legal representative of the complainant consents in writing to the disclosure and specifies to whom the disclosure may be made.

(2) The identity of any complainant, or an individual providing information on behalf of the complainant, shall be confidential. If the complaint becomes the subject of judicial proceedings, the information held by the ombudsman or the designee shall be disclosed for the purpose of the proceedings if requested by the court.

SECTION 8. There is appropriated to the Department of Consumer and Business Ser-

vices, for the biennium beginning July 1, 2025, out of the General Fund, the amount of $500,000 for the purpose of carrying out the provisions of sections 6 and 7 of this 2025 Act.

CAPTIONS

SECTION 9. The unit captions used in this 2025 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2025 Act.

OPERATIVE DATE AND EMERGENCY CLAUSE

SECTION 10. (1) Sections 5 to 7 of this 2025 Act become operative on January 1, 2026.

(2) The Department of Consumer and Business Services may take any action before the operative date specified in subsection (1) of this section that is necessary for the department to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the department by sections 5 to 7 of this 2025 Act.

SECTION 11. This 2025 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2025 Act takes effect on its passage.