

## HOUSE AMENDMENTS TO HOUSE BILL 3046

By COMMITTEE ON BEHAVIORAL HEALTH

April 15

1 On page 1 of the printed bill, line 2, after the semicolon delete the rest of the line and insert  
2 “creating new provisions; and amending ORS 414.766, 743A.168 and 743B.505.”.

3 Delete lines 4 through 31 and delete pages 2 through 8 and insert:

4 **“SECTION 1. Section 2 of this 2021 Act is added to and made a part of the Insurance**  
5 **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 International Classification of**  
20 **Disease or that is listed in the mental disorders section of the current edition of the Diag-**  
21 **nostic 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-**  
26 **ries listed in the substance use section of the current edition of the International Classi-**  
27 **fication of Disease or that is listed in the substance use section of the current edition of the**  
28 **Diagnostic and Statistical Manual of Mental Disorders.**

29 **“(2) Each carrier that offers an individual or group health benefit plan in this state that**  
30 **provides behavioral health benefits shall conduct an annual analysis of whether the pro-**  
31 **cesses, strategies, specific evidentiary standards or other factors the carrier used to design,**  
32 **determine applicability of and apply each nonquantitative treatment limitation to behavioral**  
33 **health benefits within each classification of benefits are comparable to, and are applied no**  
34 **more stringently than, the processes, strategies, specific evidentiary standards or other**  
35 **factors the carrier used to design, determine applicability of and apply each nonquantitative**

1 treatment limitation to medical and surgical benefits within the corresponding classification  
2 of benefits.

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

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

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

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

17 “(d) The comparative analyses demonstrating that the processes, strategies, evidentiary  
18 standards and other factors used to apply the nonquantitative treatment limitations to  
19 mental health or substance use disorder benefits, as written and in operation, are compara-  
20 ble to, and are applied no more stringently than, the processes, strategies, evidentiary stan-  
21 dards and other factors used to apply the nonquantitative treatment limitations to medical  
22 or surgical benefits in the benefits classification.

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

27 “(f) The number of denials of behavioral health benefits and medical and surgical bene-  
28 fits, the percentage of denials that were appealed, the percentage of appeals that upheld the  
29 denial and the percentage of appeals that overturned the denial.

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

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

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

37 “(A) Psychiatrists.

38 “(B) Psychiatric mental health nurse practitioners.

39 “(C) Psychologists.

40 “(D) Licensed clinical social workers.

41 “(E) Licensed professional counselors.

42 “(F) Licensed marriage and family therapists.

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

45 “(A) Physicians.

1       **“(B) Physician assistants.**  
2       **“(C) Licensed nurse practitioners.**  
3       **“(k) The specific findings and conclusions of the carrier under subsection (2) of this**  
4 **section demonstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete**  
5 **Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules**  
6 **adopted thereunder.**  
7       **“(L) Other data or information the department deems necessary to assess a carrier’s**  
8 **compliance with mental health parity requirements.**  
9       **“(4) No later than September 15 of each calendar year, the department shall report to the**  
10 **interim committees of the Legislative Assembly related to mental or behavioral health, in**  
11 **the manner provided in ORS 192.245, the information reported under subsection (3) of this**  
12 **section, including the department’s overall comparison of carriers’ coverage of mental health**  
13 **treatment and services and substance use disorder treatment and services to carriers’ cov-**  
14 **erage of medical or surgical treatments or services.**  
15       **“SECTION 3. (1) As used in this section:**  
16       **“(a) ‘Behavioral health coverage’ means mental health treatment and services and sub-**  
17 **stance use disorder treatment or services reimbursed by a coordinated care organization.**  
18       **“(b) ‘Coordinated care organization’ has the meaning given that term in ORS 414.025.**  
19       **“(c) ‘Mental health treatment and services’ means the treatment of or services provided**  
20 **to address any condition or disorder that falls under any of the diagnostic categories listed**  
21 **in the mental disorders section of the current edition of the International Classification of**  
22 **Disease or that is listed in the mental disorders section of the current edition of the Diag-**  
23 **nostic and Statistical Manual of Mental Disorders.**  
24       **“(d) ‘Nonquantitative treatment limitation’ means a limitation that is not expressed nu-**  
25 **merically but otherwise limits the scope or duration of behavioral health coverage, such as**  
26 **medical necessity criteria or other utilization review.**  
27       **“(e) ‘Substance use disorder treatment and services’ means the treatment of and any**  
28 **services provided to address any condition or disorder that falls under any of the diagnostic**  
29 **categories listed in the substance use section of the current edition of the International**  
30 **Classification of Disease or that is listed in the substance use section of the current edition**  
31 **of the Diagnostic and Statistical Manual of Mental Disorders.**  
32       **“(2) On or before June 1 of each year, each coordinated care organization shall report to**  
33 **the Oregon Health Authority information about the coordinated care organization’s compli-**  
34 **ance with mental health parity requirements, including but not limited to the following:**  
35       **“(a) The specific plan or coverage terms or other relevant terms regarding the non-**  
36 **quantitative treatment limitations and a description of all mental health or substance use**  
37 **disorder benefits and medical or surgical benefits to which each such term applies in each**  
38 **respective benefits classification.**  
39       **“(b) The factors used to determine that the nonquantitative treatment limitations will**  
40 **apply to mental health or substance use disorder benefits and medical or surgical benefits.**  
41       **“(c) The evidentiary standards used for the factors identified in paragraph (b) of this**  
42 **subsection, when applicable, provided that every factor is defined, and any other source or**  
43 **evidence relied upon to design and apply the nonquantitative treatment limitations to mental**  
44 **health or substance use disorder benefits and medical or surgical benefits.**  
45       **“(d) The number of denials of coverage of mental health treatment and services, sub-**

1 stance use disorder treatment and services and medical and surgical treatment and services,  
2 the percentage of denials that were appealed, the percentage of appeals that upheld the de-  
3 nial and the percentage of appeals that overturned the denial.

4 “(e) The percentage of claims for behavioral health coverage and for coverage of medical  
5 and surgical treatments that were paid to in-network providers and the percentage of such  
6 claims that were paid to out-of-network providers.

7 “(f) Other data or information the authority deems necessary to assess a coordinated  
8 care organization’s compliance with mental health parity requirements.

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

16 “(4) Each calendar year the authority, in collaboration with individuals representing be-  
17 havioral health treatment providers, community mental health programs and consumers of  
18 mental health or substance use disorder treatment, shall, based on the information reported  
19 under subsection (2) of this section, identify and assess the parity between the behavioral  
20 health coverage and the coverage of medical and surgical treatment in the medical assist-  
21 ance program. No later than October 4 of each calendar year, the authority shall report to  
22 the interim committees of the Legislative Assembly related to mental or behavioral health,  
23 in the manner provided in ORS 192.245, the authority’s findings on parity and an assessment  
24 of all of the following, including a comparison of coverage for members of coordinated care  
25 organizations to coverage for medical assistance recipients who are not enrolled in coordi-  
26 nated care organizations:

27 “(a) The adequacy of the network of providers.

28 “(b) The timeliness of access to mental health and substance use disorder treatment and  
29 services.

30 “(c) The criteria used by each coordinated care organization to determine medical ne-  
31 cessity and behavioral health coverage, including each coordinated care organization’s pay-  
32 ment protocols and procedures.

33 “(d) The consistency of credentialing requirements for behavioral health treatment pro-  
34 viders with the credentialing of medical and surgical treatment providers.

35 “(e) The utilization review applied to behavioral health coverage compared to coverage  
36 of medical and surgical treatments.

37 “(f) The specific findings and conclusions reached by the authority with respect to the  
38 coverage of mental health and substance use disorder treatment and the authority’s analysis  
39 that indicates that the coverage is or is not in compliance with this section.

40 “(g) The specific findings and conclusions of the authority demonstrating a coordinated  
41 care organization’s compliance with this section and with the Paul Wellstone and Pete  
42 Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules  
43 adopted thereunder.

44 “**SECTION 4.** ORS 414.766 is amended to read:

45 “414.766. (1) Notwithstanding ORS 414.065 and 414.690, a coordinated care organization must

1 provide behavioral health services to its members that include but are not limited to all of the fol-  
2 lowing:

3 “[1] (a) For a member who is experiencing a behavioral health crisis:

4 “[a] (A) A behavioral health assessment; and

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

7 “[2] (b) At least the minimum level of services that are medically necessary to treat a  
8 member’s **underlying** behavioral health condition **rather than a mere amelioration of current**  
9 **symptoms, such as suicidal ideation or psychosis**, as determined in a behavioral health assess-  
10 ment of the member or specified in the member’s care plan; [and]

11 “(c) **Treatment of co-occurring behavioral health disorders or medical conditions in a**  
12 **coordinated manner;**

13 “(d) **Treatment at the least intensive and least restrictive level of care that is safe and**  
14 **effective and meets the needs of the individual’s condition;**

15 “(e) **For all level of care placement decisions, placement at the level of care consistent**  
16 **with a member’s score or assessment using the relevant level of care placement criteria and**  
17 **guidelines;**

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

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

21 “(h) **Treatment for an appropriate duration based on the individual’s particular needs;**

22 “(i) **Treatment appropriate to the unique needs of children and adolescents;**

23 “(j) **Treatment appropriate to the unique needs of older adults;**

24 “(k) **Treatment that is culturally and linguistically appropriate;**

25 “(L) **Treatment that is appropriate to the unique needs of gay, lesbian, bisexual and**  
26 **transgender individuals and individuals of any other minority gender identity or sexual ori-**  
27 **entation; and**

28 “[3] (m) Coordinated care and case management as defined by the Department of Consumer  
29 and Business Services by rule.

30 “(2) **If there is a disagreement about the level of care required by subsection (1)(e) or (f)**  
31 **of this subsection, a coordinated care organization shall provide to the behavioral health**  
32 **treatment provider full details of the coordinated care organization’s scoring or assessment**  
33 **using the relevant level of care placement criteria and guidelines.**

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

36 “**SECTION 5.** ORS 743A.168 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  
41 of Consumer and Business Services.

42 “[b] (c) ‘Behavioral health crisis’ means a disruption in an [individual’s] **insured’s** mental or  
43 emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in  
44 an emergency department or admission to a hospital to prevent a serious deterioration in the  
45 [individual’s] **insured’s** mental or physical health.

1       “(c) ‘Chemical dependency’ means the addictive relationship with any drug or alcohol character-  
2 ized by a physical or psychological relationship, or both, that interferes on a recurring basis with the  
3 individual’s social, psychological or physical adjustment to common problems. For purposes of this  
4 section, ‘chemical dependency’ does not include addiction to, or dependency on, tobacco, tobacco pro-  
5 ducts or foods.]

6       “(d) ‘Facility’ means a corporate or governmental entity or other provider of services for the  
7 treatment of [chemical dependency or for the treatment of mental or nervous conditions] **behavioral**  
8 **health conditions.**

9       “(e) ‘Generally accepted standards of care’ means:

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

11       “(i) Are generally recognized by health care providers practicing in relevant clinical spe-  
12 cialties; and

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

14       “(B) Products and services that:

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

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

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

21       “[(e)] (f) ‘Group health insurer’ means an insurer, a health maintenance organization or a health  
22 care service contractor.

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

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

27       “[(g)] (i) ‘Program’ means a particular type or level of service that is organizationally distinct  
28 within a facility.

29       “[(h)] (j) ‘Provider’ means:

30       “(A) [An individual] **A behavioral health professional or medical professional licensed or**  
31 **certified in this state** who has met the credentialing requirement of a group health insurer or an  
32 issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS  
33 743B.005[,] **and** is otherwise eligible to receive reimbursement for coverage under the policy [and is  
34 a behavioral health professional or a medical professional licensed or certified in this state];

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

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

37       “(D) A day or partial hospitalization program;

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

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

41       “(k) ‘Relevant clinical specialties’ includes but is not limited to:

42       “(A) Psychiatry;

43       “(B) Psychology;

44       “(C) Clinical sociology;

45       “(D) Addiction medicine and counseling; and

1       “(E) **Behavioral health treatment.**

2       “(L) **‘Standards of care and clinical practice guidelines’ includes but is not limited to:**

3       “(A) **Patient placement criteria;**

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

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

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

7       “(n) **‘Valid, evidence-based sources’ includes but is not limited to:**

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

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

10       “(C) **Specialty societies.**

11       “(2) A group health insurance policy or an individual health benefit plan that is not a grandfa-

12       thered health plan providing coverage for hospital or medical expenses, other than limited benefit

13       coverage, shall provide coverage for expenses arising from the diagnosis of **behavioral health**

14       **conditions** and **medically necessary behavioral health** treatment [*for chemical dependency, in-*

15       *cluding alcoholism, and for mental or nervous conditions*] at the same level as, and subject to limi-

16       tations no more restrictive than, those imposed on coverage or reimbursement of expenses arising

17       from treatment for other medical conditions. The following apply to coverage for [*chemical depend-*

18       *ency and for mental or nervous conditions*] **behavioral health treatment:**

19       “(a) The coverage may be made subject to provisions of the policy that apply **equally** to **all**

20       other benefits under the policy, including but not limited to provisions relating to **copayments,**

21       deductibles and coinsurance. **Copayments,** deductibles and coinsurance for treatment in health care

22       facilities or residential facilities may not be greater than those under the policy for expenses of

23       hospitalization in the treatment of other medical conditions. **Copayments,** deductibles and

24       coinsurance for outpatient treatment may not be greater than those under the policy for expenses

25       of outpatient treatment of other medical conditions.

26       “(b) The coverage **of behavioral health treatment** may not be made subject to treatment limi-

27       tations, limits on total payments for treatment, limits on duration of treatment or financial re-

28       quirements unless similar limitations or requirements are imposed on coverage of other medical

29       conditions. The coverage of eligible expenses **of behavioral health treatment** may be limited to

30       treatment that is medically necessary as determined **in accordance with this section and no more**

31       **stringently** under the policy **than** for other medical conditions.

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

33       “(A) A behavioral health assessment;

34       “(B) No less than the level of services determined to be medically necessary in a behavioral

35       health assessment of **the specific needs of** a patient or in a patient’s care plan:

36       “(i) To **effectively** treat the patient’s **underlying** behavioral health condition **rather than the**

37       **mere amelioration of current symptoms such as suicidal ideation or psychosis;** and

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

39       care; [*and*]

40       “(C) **Treatment of co-occurring behavioral health conditions or medical conditions in a**

41       **coordinated manner;**

42       “(D) **Treatment at the least intensive and least restrictive level of care that is safe and**

43       **most effective and meets the needs of the insured’s condition;**

44       “(E) **A lower level or less intensive care only if it is comparably as safe and effective as**

45       **treatment at a higher level of service or intensity;**

1       “(F) Treatment to maintain functioning or prevent deterioration;

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

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

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

5       “[(C)] (J) Coordinated care and case management as defined by the Department of Consumer and  
6 Business Services by rule.

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

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

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

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

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

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

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

26       “(g) A group health insurer or an issuer of an individual health benefit plan other than  
27 a grandfathered health plan must use the same methodology to set reimbursement rates paid  
28 to behavioral health treatment providers that the group health insurer or issuer of an indi-  
29 vidual health benefit plan uses to set reimbursement rates for medical and surgical treat-  
30 ment providers.

31       “(h) A group health insurer or an issuer of an individual health benefit plan other than  
32 a grandfathered health plan must update the methodology and rates for reimbursing behav-  
33 ioral health treatment providers no less frequently than the group health insurer or issuer  
34 of an individual health benefit plan updates the methodology and rates for reimbursing  
35 medical and surgical treatment providers, unless otherwise required by federal law.

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

41       “[(e)] (j) [If specified in the policy,] Outpatient coverage of behavioral health treatment [may]  
42 shall include follow-up in-home service or outpatient services if clinically indicated under any  
43 medical necessity, utilization or other clinical review conducted for the diagnosis, prevention  
44 or treatment of behavioral health conditions or relating to service intensity, level of care  
45 placement, continued stay or discharge. The policy may limit coverage for in-home service to



1 persons who are homebound under the care of a physician **only if clinically indicated under any**  
2 **medical necessity, utilization or other clinical review conducted for the diagnosis, prevention**  
3 **or treatment of behavioral health conditions or relating to service intensity, level of care**  
4 **placement, continued stay or discharge.**

5 “[(f)(A)] (k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating  
6 to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS  
7 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed  
8 professional counselors and licensed marriage and family therapists, a group health insurer or issuer  
9 of an individual health benefit plan may provide for review for level of treatment of admissions and  
10 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization  
11 programs and outpatient services by either staff of a group health insurer or issuer of an individual  
12 health benefit plan or personnel under contract to the group health insurer or issuer of an individual  
13 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,  
14 who shall have the authority to certify for or deny level of payment.

15 “(B) Review shall be made according to criteria made available to providers in advance upon  
16 request.

17 “(C) Review shall be performed by or under the direction of a physician licensed under ORS  
18 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
19 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
20 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
21 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
22 Medicare review standards of the Centers for Medicare and Medicaid Services.

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

33 “[g] (L) Health maintenance organizations may limit the receipt of covered services by  
34 enrollees to services provided by or upon referral by providers contracting with the health mainte-  
35 nance organization. Health maintenance organizations and health care service contractors may  
36 create substantive plan benefit and reimbursement differentials at the same level as, and subject to  
37 limitations no more restrictive than, those imposed on coverage or reimbursement of expenses aris-  
38 ing out of other medical conditions and apply them to contracting and noncontracting providers.

39 “(3) This section does not prohibit a group health insurer or issuer of an individual health ben-  
40 efit plan that is not a grandfathered health plan from managing the provision of benefits through  
41 common methods, including but not limited to selectively contracted panels, health plan benefit dif-  
42 ferential designs, preadmission screening, prior authorization of services, utilization review or other  
43 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section  
44 **provided such methods comply with the requirements of this section.**

45 “(4) The Legislative Assembly finds that health care cost containment is necessary and intends

1 to encourage health insurance plans designed to achieve cost containment by ensuring that re-  
2 imbursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-  
3 ther directly or by reference, **in accordance with this section.**

4 **“(5) To ensure the proper use of any medical necessity, utilization or other clinical review**  
5 **conducted for the diagnosis, prevention or treatment of behavioral health conditions or re-**  
6 **lating to service intensity, level of care placement, continued stay or discharge, a group**  
7 **health insurer or an issuer of an individual health benefit plan shall:**

8 **“(a) Sponsor a formal education program by nonprofit clinical specialty associations to**  
9 **educate the insurer’s or issuer’s staff and any individuals described in subsection (2)(k) of**  
10 **this section who conduct reviews.**

11 **“(b) Make the education program available to other stakeholders, including participating**  
12 **providers and insureds. Participating providers shall not be required to participate in the**  
13 **education program.**

14 **“(c) Provide, at no cost, the medical necessity, utilization or other clinical review criteria**  
15 **and any training material or resources to providers and insureds.**

16 “[5] **(6)** This section does not prevent a group health insurer or issuer of an individual health  
17 benefit plan that is not a grandfathered health plan from contracting with providers of health care  
18 services to furnish services to policyholders or certificate holders according to ORS 743B.460 or  
19 750.005, subject to the following conditions:

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

23 **“(b)** An insurer or health care service contractor shall, subject to subsection (2) of this section,  
24 pay benefits toward the covered charges of noncontracting providers of services for *[the]* **behavioral**  
25 **health** treatment *[of chemical dependency or mental or nervous conditions]*. The insured shall, subject  
26 to subsection (2) of this section, have the right to use the services of a noncontracting provider of  
27 *[services for the]* **behavioral health** treatment *[of chemical dependency or mental or nervous condi-*  
28 *tions]*, whether or not the *[services for chemical dependency or mental or nervous conditions are]* **be-**  
29 **havioral health treatment is** provided by contracting or noncontracting providers.

30 “[6)(a)] **(7)(a)** This section does not require coverage for:

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

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

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

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

40 **“(E)** Support groups.

41 **“(b)** Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered out-  
42 patient services under the terms of the insured’s policy while the insured is living temporarily in a  
43 sheltered living situation.

44 “[7)] **(8)** The Oregon Health Authority shall establish a process for the certification of an or-  
45 ganization described in subsection *[(1)(h)(F)]* **(1)(j)(F)** of this section that:

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

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

4 “[8] (9) The Oregon Health Authority shall adopt by rule standards for the certification pro-  
5 vided under subsection [(7)] (8) of this section to ensure that a certified provider organization offers  
6 a distinct and specialized program for the treatment of mental or nervous conditions.

7 “[9] (10) The Oregon Health Authority may adopt by rule an application fee or a certification  
8 fee, or both, to be imposed on any provider organization that applies for certification under sub-  
9 section [(7)] (8) of this section. Any fees collected shall be paid into the Oregon Health Authority  
10 Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection  
11 [(7)] (8) of this section.

12 “[10] (11) The intent of the Legislative Assembly in adopting this section is to reserve benefits  
13 for different types of care to encourage cost effective care and to ensure continuing access to levels  
14 of care most appropriate for the insured’s condition and progress **in accordance with this**  
15 **section**. This section does not prohibit an insurer from requiring a provider organization certified  
16 by the Oregon Health Authority under subsection [(7)] (8) of this section to meet the insurer’s cre-  
17 dentialing requirements as a condition of entering into a contract.

18 “[11] (12) The Director of the Department of Consumer and Business Services and the Oregon  
19 Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this  
20 section that are considered necessary for the proper administration of this section. **The director**  
21 **shall adopt rules making it a violation of this section for a group health insurer or issuer**  
22 **of an individual health benefit plan other than a grandfathered health plan to require pro-**  
23 **viders to bill using a specific billing code or to restrict the reimbursement paid for particular**  
24 **billing codes other than on the basis of medical necessity.**

25 “(13) This section does not:

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

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

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

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

34 “743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to  
35 individuals or to small employers, as defined in ORS 743B.005, through a specified network of health  
36 care providers shall:

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

41 “(b)(A) With respect to health benefit plans offered through the health insurance exchange under  
42 ORS 741.310, contract with a sufficient number and geographic distribution of essential community  
43 providers, where available, to ensure reasonable and timely access to a broad range of essential  
44 community providers for low-income, medically underserved individuals in the plan’s service area in  
45 accordance with the network adequacy standards established by the Department of Consumer and

1 Business Services;

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

8 “(C) With respect to health benefit plans offered outside of the health insurance exchange,  
9 contract with or employ a network of providers that is sufficient in number, geographic distribution  
10 and types of providers to ensure access to care by enrollees who reside in locations within the  
11 health benefit plan’s service area that are designated by the Health Resources and Services Ad-  
12 ministration of the United States Department of Health and Human Services as health professional  
13 shortage areas or low-income zip codes.

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

17 “(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan  
18 or coverage under the plan against any health care provider who is acting within the scope of the  
19 provider’s license or certification in this state.

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

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

24 “(d) Rules adopted by the Department of Consumer and Business Services to implement this  
25 section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the  
26 United States Department of Health and Human Services, the United States Department of the  
27 Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect  
28 on January 1, 2017.

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

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

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

35 “(B) Consumer satisfaction;

36 “(C) Transparency; and

37 “(D) Quality of care and cost containment; or

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

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

42 “(a) **An adequate number and geographic distribution, as prescribed by the department**  
43 **by rule, of licensed professional counselors, licensed marriage and family therapists, licensed**  
44 **clinical social workers, psychologists and psychiatrists who are accepting new patients, based**  
45 **on the needs of the insureds under the policy or certificate, including but not limited to**

1 providers who can address the needs of:

2 “(A) Children and adults;

3 “(B) Individuals with limited English proficiency or who are illiterate;

4 “(C) Individuals with diverse cultural or ethnic backgrounds;

5 “(D) Individuals with chronic or complex behavioral health conditions; and

6 “(E) Other groups specified by the department by rule; and

7 “(b) An adequate number of the providers described in paragraph (a) of this subsection  
8 in all geographic areas where the insurer offers plans.

9 “[4] (5) This section does not require an insurer to contract with an essential community pro-  
10 vider that refuses to accept the insurer’s generally applicable payment rates for services covered  
11 by the plan.

12 “[5] (6) This section does not require an insurer to submit provider contracts to the department  
13 for review.”.

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

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

16 “(a) ‘Behavioral health benefits’ means insurance coverage of mental health treatment and ser-  
17 vices and substance use disorder treatment and services.

18 “(b) ‘Carrier’ has the meaning given that term in ORS 743B.005.

19 “(c) ‘Geographic region’ means the geographic area of the state established by the Department  
20 of Consumer and Business Services for the purpose of determining geographic average rates, as de-  
21 fined in ORS 743B.005.

22 “(d) ‘Health benefit plan’ has the meaning given that term in ORS 743B.005.

23 “(e) ‘Median maximum allowable reimbursement rate’ means the median of all maximum allow-  
24 able reimbursement rates, minus incentive payments, paid for each billing code for each provider  
25 type during a calendar year.

26 “(f) ‘Mental health treatment and services’ means the treatment of or services provided to ad-  
27 dress any condition or disorder that falls under any of the diagnostic categories listed in the mental  
28 disorders section of the current edition of the International Classification of Disease or that is listed  
29 in the mental disorders section of the current edition of the Diagnostic and Statistical Manual of  
30 Mental Disorders.

31 “(g) ‘Nonquantitative treatment limitation’ means a limitation that is not expressed numerically  
32 but otherwise limits the scope or duration of behavioral health benefits.

33 “(h) ‘Substance use disorder treatment and services’ means the treatment of or services provided  
34 to address any condition or disorder that falls under any of the diagnostic categories listed in the  
35 substance use section of the current edition of the International Classification of Disease or that is  
36 listed in the substance use section of the current edition of the Diagnostic and Statistical Manual  
37 of Mental Disorders.

38 “(2) Each carrier that offers an individual or group health benefit plan in this state that pro-  
39 vides behavioral health benefits shall conduct an annual analysis of whether the processes, strate-  
40 gies, specific evidentiary standards or other factors the carrier used to design, determine  
41 applicability of and apply each nonquantitative treatment limitation to behavioral health benefits  
42 within each classification of benefits are comparable to, and are applied no more stringently than,  
43 the processes, strategies, specific evidentiary standards or other factors the carrier used to design,  
44 determine applicability of and apply each nonquantitative treatment limitation to medical and sur-  
45 gical benefits within the corresponding classification of benefits.

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

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

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

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

14 “(d) The comparative analyses demonstrating that the processes, strategies, evidentiary stan-  
15 dards and other factors used to apply the nonquantitative treatment limitations to mental health or  
16 substance use disorder benefits, as written and in operation, are comparable to, and are applied no  
17 more stringently than, the processes, strategies, evidentiary standards and other factors used to  
18 apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits clas-  
19 sification.

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

23 “[*f*] *The number of denials of behavioral health benefits and medical and surgical benefits, the*  
24 *percentage of denials that were appealed, the percentage of appeals that upheld the denial and the*  
25 *percentage of appeals that overturned the denial.*]

26 “[*g*] *The percentage of claims for behavioral health benefits and medical and surgical benefits that*  
27 *were paid to in-network providers and the percentage of such claims that were paid to out-of-network*  
28 *providers.*]

29 “[*h*] *The median maximum allowable reimbursement rate for each time-based office visit billing*  
30 *code for each behavioral treatment provider type and each medical provider type.*]

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

33 “[*(A)* *Psychiatrists.*]

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

35 “[*(C)* *Psychologists.*]

36 “[*(D)* *Licensed clinical social workers.*]

37 “[*(E)* *Licensed professional counselors.*]

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

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

41 “[*(A)* *Physicians.*]

42 “[*(B)* *Physician assistants.*]

43 “[*(C)* *Licensed nurse practitioners.*]

44 “[*k*] *The specific findings and conclusions of the carrier under subsection (2) of this section dem-*  
45 *onstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health*

1 *Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.]*

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

4 “(4) No later than September 15 of each calendar year, the department shall report to the in-  
5 terim committees of the Legislative Assembly related to mental or behavioral health, in the manner  
6 provided in ORS 192.245, the information reported under subsection (3) of this section, including the  
7 department’s overall comparison of carriers’ coverage of mental health treatment and services and  
8 substance use disorder treatment and services to carriers’ coverage of medical or surgical treat-  
9 ments or services.

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

11 “743A.168. (1) As used in this section:

12 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in person or using tele-  
13 medicine, to determine a patient’s need for behavioral health treatment.

14 “(b) ‘Behavioral health condition’ has the meaning prescribed by rule by the Department of  
15 Consumer and Business Services.

16 “(c) ‘Behavioral health crisis’ means a disruption in an insured’s mental or emotional stability  
17 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
18 partment or admission to a hospital to prevent a serious deterioration in the insured’s mental or  
19 physical health.

20 “(d) ‘Facility’ means a corporate or governmental entity or other provider of services for the  
21 treatment of behavioral health conditions.

22 “(e) ‘Generally accepted standards of care’ means:

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

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

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

27 “(B) Products and services that:

28 “(i) Address the specific needs of a patient for the purpose of screening for, preventing, diag-  
29 nosing, managing or treating an illness, injury or condition or symptoms of an illness, injury or  
30 condition;

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

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

34 “(f) ‘Group health insurer’ means an insurer, a health maintenance organization or a health care  
35 service contractor.

36 “(g) ‘Median maximum allowable reimbursement rate’ means the median of all maximum allow-  
37 able reimbursement rates, minus incentive payments, paid for each billing code for each provider  
38 type during a calendar year.

39 “(h) ‘Prior authorization’ has the meaning given that term in ORS 743B.001.

40 “(i) ‘Program’ means a particular type or level of service that is organizationally distinct within  
41 a facility.

42 “(j) ‘Provider’ means:

43 “(A) A behavioral health professional or medical professional licensed or certified in this state  
44 who has met the credentialing requirement of a group health insurer or an issuer of an individual  
45 health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is oth-

1 erwise eligible to receive reimbursement for coverage under the policy;

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

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

4 “(D) A day or partial hospitalization program;

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

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

8 “(k) ‘Relevant clinical specialties’ includes but is not limited to:

9 “(A) Psychiatry;

10 “(B) Psychology;

11 “(C) Clinical sociology;

12 “(D) Addiction medicine and counseling; and

13 “(E) Behavioral health treatment.

14 “(L) ‘Standards of care and clinical practice guidelines’ includes but is not limited to:

15 “(A) Patient placement criteria;

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

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

18 “(m) ‘Utilization review’ has the meaning given that term in ORS 743B.001.

19 “(n) ‘Valid, evidence-based sources’ includes but is not limited to:

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

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

22 “(C) Specialty societies.

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

30 “(a) The coverage may be made subject to provisions of the policy that apply equally to all other  
31 benefits under the policy, including but not limited to provisions relating to copayments, deductibles  
32 and coinsurance. Copayments, deductibles and coinsurance for treatment in health care facilities or  
33 residential facilities may not be greater than those under the policy for expenses of hospitalization  
34 in the treatment of other medical conditions. Copayments, deductibles and coinsurance for outpa-  
35 tient treatment may not be greater than those under the policy for expenses of outpatient treatment  
36 of other medical conditions.

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

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

44 “(A) A behavioral health assessment;

45 “(B) No less than the level of services determined to be medically necessary in a behavioral



1 health assessment of the specific needs of a patient or in a patient's care plan:

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

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

6 "(C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordi-  
7 nated manner;

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

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

12 "(F) Treatment to maintain functioning or prevent deterioration;

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

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

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

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

18 "(d) The coverage of behavioral health treatment may not limit coverage for treatment of per-  
19 vasive or chronic behavioral health conditions to short-term or acute behavioral health treatment  
20 at any level of care or placement.

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

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

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

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

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

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

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

40 "(h) A group health insurer or an issuer of an individual health benefit plan other than a  
41 grandfathered health plan must update the methodology and rates for reimbursing behavioral health  
42 treatment providers no less frequently than the group health insurer or issuer of an individual  
43 health benefit plan updates the methodology and rates for reimbursing medical and surgical treat-  
44 ment providers, unless otherwise required by federal law.

45 "(i) A group health insurer or an issuer of an individual health benefit plan other than a

1 grandfathered health plan that reimburses out-of-network providers for medical or surgical services  
2 must reimburse out-of-network behavioral health treatment providers on the same terms and at a  
3 rate that is in parity with the rate paid to medical or surgical treatment providers.

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

13 “(k)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to phy-  
14 sicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250  
15 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-  
16 sional counselors and licensed marriage and family therapists, a group health insurer or issuer of  
17 an individual health benefit plan may provide for review for level of treatment of admissions and  
18 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization  
19 programs and outpatient services by either staff of a group health insurer or issuer of an individual  
20 health benefit plan or personnel under contract to the group health insurer or issuer of an individual  
21 health benefit plan that is not a grandfathered health plan, or by a utilization review contractor,  
22 who shall have the authority to certify for or deny level of payment.

23 “(B) Review shall be made according to criteria made available to providers in advance upon  
24 request.

25 “(C) Review shall be performed by or under the direction of a physician licensed under ORS  
26 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
27 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
28 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
29 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
30 Medicare review standards of the Centers for Medicare and Medicaid Services.

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

41 “(L) Health maintenance organizations may limit the receipt of covered services by enrollees to  
42 services provided by or upon referral by providers contracting with the health maintenance organ-  
43 ization. Health maintenance organizations and health care service contractors may create substan-  
44 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no  
45 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other

1 medical conditions and apply them to contracting and noncontracting providers.

2 “(3) This section does not prohibit a group health insurer or issuer of an individual health ben-  
3 efit plan that is not a grandfathered health plan from managing the provision of benefits through  
4 common methods, including but not limited to selectively contracted panels, health plan benefit dif-  
5 ferential designs, preadmission screening, prior authorization of services, utilization review or other  
6 mechanisms designed to limit eligible expenses to those described in subsection (2)(b) of this section  
7 provided such methods comply with the requirements of this section.

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

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

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

17 “(B) **The most recent version of the levels of care placement criteria and practice  
18 guidelines developed by the nonprofit professional association for the relevant clinical spe-  
19 cialty.**

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

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

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

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

36 “[5] (6) To ensure the proper use of [*any medical necessity, utilization or other clinical review*  
37 *conducted for the diagnosis, prevention or treatment of behavioral health conditions or relating to ser-*  
38 *vice intensity, level of care placement, continued stay or discharge]* **the criteria and guidelines de-**  
39 **scribed in subsection (5) of this section,** a group health insurer or an issuer of an individual  
40 health benefit plan shall:

41 “(a) Sponsor a formal education program by nonprofit clinical specialty associations to educate  
42 the insurer’s or issuer’s staff and any individuals described in subsection (2)(k) of this section who  
43 conduct reviews.

44 “(b) Make the education program available to other stakeholders, including participating pro-  
45 viders and insureds. Participating providers shall not be required to participate in the education

1 program.

2 “(c) Provide, at no cost, the [*medical necessity, utilization or other clinical review criteria*] **cri-**  
3 **teria and guidelines described in subsection (5) of this section** and any training material or re-  
4 sources to providers and insureds.

5 “[*(6)*] **(7)** This section does not prevent a group health insurer or issuer of an individual health  
6 benefit plan that is not a grandfathered health plan from contracting with providers of health care  
7 services to furnish services to policyholders or certificate holders according to ORS 743B.460 or  
8 750.005, subject to the following conditions:

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

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

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

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

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

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

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

28 “(E) Support groups.

29 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered out-  
30 patient services under the terms of the insured’s policy while the insured is living temporarily in a  
31 sheltered living situation.

32 “[*(8)*] **(9)** The Oregon Health Authority shall establish a process for the certification of an or-  
33 ganization described in subsection (1)(j)(F) of this section that:

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

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

37 “[*(9)*] **(10)** The Oregon Health Authority shall adopt by rule standards for the certification pro-  
38 vided under subsection [*(8)*] **(9)** of this section to ensure that a certified provider organization offers  
39 a distinct and specialized program for the treatment of mental or nervous conditions.

40 “[*(10)*] **(11)** The Oregon Health Authority may adopt by rule an application fee or a certification  
41 fee, or both, to be imposed on any provider organization that applies for certification under sub-  
42 section [*(8)*] **(9)** of this section. Any fees collected shall be paid into the Oregon Health Authority  
43 Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection  
44 [*(8)*] **(9)** of this section.

45 “[*(11)*] **(12)** The intent of the Legislative Assembly in adopting this section is to reserve benefits

1 for different types of care to encourage cost effective care and to ensure continuing access to levels  
2 of care most appropriate for the insured's condition and progress in accordance with this section.  
3 This section does not prohibit an insurer from requiring a provider organization certified by the  
4 Oregon Health Authority under subsection [(8)] (9) of this section to meet the insurer's credentialing  
5 requirements as a condition of entering into a contract.

6 “[12] (13) The Director of the Department of Consumer and Business Services and the Oregon  
7 Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this  
8 section that are considered necessary for the proper administration of this section. The director  
9 shall adopt rules making it a violation of this section for a group health insurer or issuer of an in-  
10 dividual health benefit plan other than a grandfathered health plan to require providers to bill using  
11 a specific billing code or to restrict the reimbursement paid for particular billing codes other than  
12 on the basis of medical necessity.

13 “[13] (14) This section does not:

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

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

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

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

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