HB 3046-2
(LC 1535)
2/15/21 (LHF/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO HOUSE BILL 3046

1 On page 1 of the printed bill, line 2, after the semicolon delete the rest
2 of the line and insert "creating new provisions; and amending ORS 414.766,
3 743A.168 and 743B.505.".
4 Delete lines 4 through 31 and delete pages 2 through 8 and insert:
5 **"SECTION 1. Section 2 of this 2021 Act is added to and made a part**
6 **of the Insurance Code.**
7 **"SECTION 2. (1) As used in this section:**
8 **"(a) 'Behavioral health benefits' means insurance coverage of**
9 **mental health treatment and services and substance use disorder**
10 **treatment and services.**
11 **"(b) 'Behavioral health treatment provider' includes a:**
12 **"(A) Psychiatrist.**
13 **"(B) Psychologist.**
14 **"(C) Licensed professional counselor.**
15 **"(D) Licensed marriage and family therapist.**
16 **"(E) Licensed clinical social worker.**
17 **"(F) Licensed nurse practitioner.**
18 **"(G) Physician.**
19 **"(H) Physician assistant.**
20 **"(c) 'Carrier' has the meaning given that term in ORS 743B.005.**
21 **"(d) '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.

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

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

"(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 International Classification of Disease or that is listed in the mental disorders section of the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

"(h) 'Nonquantitative treatment limitation' means a limitation that is not expressed numerically but otherwise limits the scope or duration of behavioral health benefits, such as medical necessity criteria or other utilization review.

"(i) '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 International Classification of Disease or that is listed in the substance use section of the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

"(j) 'Third party administrator' means a person licensed under ORS 744.702.

"(2) Each carrier that offers an individual or group health benefit plan in this state that provides behavioral health benefits, and each third party administrator that administers claims for behavioral

health benefits, shall conduct an annual analysis of whether the processes, strategies, specific evidentiary standards or other factors the carrier or third party administrator used to design, determine applicability 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 or third party administrator used to design, determine applicability 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 and all third party administrators that administer claims for 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) A description of the process the carrier or third party administrator used in developing and selecting the medical necessity criteria for behavioral health benefits and the process the carrier or third party administrator used in developing and selecting the medical necessity criteria for medical and surgical benefits.

"(b) A description of all nonquantitative treatment limitations that the carrier or third party administrator applies to behavioral health benefits and medical and surgical benefits.

"(c) The carrier's or third party administrator's analysis of the processes, strategies, specific evidentiary standards or other factors that were used to design, determine applicability and apply the nonquantitative treatment limitations to behavioral health benefits compared to medical and surgical benefits, including any factors that were

1 **considered and rejected.**

2 **"(d) The carrier's or third party administrator's analysis in con-**
3 **cluding that the design and the processes, strategies, specific**
4 **evidentiary standards or other factors that were used to design, de-**
5 **termine applicability and apply the nonquantitative treatment limita-**
6 **tions to behavioral health benefits were no more stringent than for**
7 **medical and surgical benefits.**

8 **"(e) The number of denials of behavioral health benefits and med-**
9 **ical and surgical benefits, the percentage of denials that were ap-**
10 **pealed, the percentage of appeals that upheld the denial and the**
11 **percentage of appeals that overturned the denial.**

12 **"(f) The percentage of claims for behavioral health benefits and**
13 **medical and surgical benefits that were paid to in-network providers**
14 **and the percentage of such claims that were paid to out-of-network**
15 **providers.**

16 **"(g) The median maximum allowable reimbursement rate for each**
17 **billing code for each behavioral health treatment provider type which**
18 **will indicate whether percentage increases in rates for medical and**
19 **surgical services were relatively equivalent to the increases in rates**
20 **for behavioral health treatments and services over time.**

21 **"(h) The reimbursement rate in each geographic region for a time-**
22 **based office visit and the percentage of the Medicare rate the re-**
23 **imbursement rate represents, paid to:**

24 **"(A) Psychiatrists.**

25 **"(B) Psychiatric mental health nurse practitioners.**

26 **"(C) Psychologists.**

27 **"(D) Licensed clinical social workers.**

28 **"(E) Licensed professional counselors.**

29 **"(F) Licensed marriage and family therapists.**

30 **"(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) Physicians.

"(B) Physician assistants.

"(C) Licensed nurse practitioners.

"(j) The specific findings and conclusions in the carrier's or third party administrator's analyses 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.

"(k) Other data or information the department deems necessary to assess a carrier's or third party administrator's compliance with mental health parity requirements.

"(4) 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 data reported under subsection (3) of this section including the department's overall comparison of the coverage by carriers and third party administrators of mental health treatment and services and substance use disorder treatment or services with coverage provided for medical or surgical treatments or services.

"SECTION 3. (1) The Department of Consumer and Business Services shall establish a mental health parity advisory committee to review annual reports submitted under section 2 of this 2021 Act, best practices or other topics and suggest changes to the department's administrative rules or guidance or suggest legislative changes that may be requested by the department to ensure that insurers and third party administrators in this state comply with ORS 743A.168, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

"(2) The committee must consist of:

"(a) Four members representing insurers;

"(b) Four members who are psychiatrists, psychologists, psychiatric mental health nurse practitioners, licensed clinical social workers, licensed marriage and family therapists or licensed professional counselors; and

"(c) Two members who are consumers of behavioral health treatment or advocates for consumers of behavioral health treatment.

"SECTION 4. (1) As used in this section:

"(a) 'Behavioral health coverage' means mental health treatment and services and substance use disorder treatment or services reimbursed by a coordinated care organization.

"(b) 'Coordinated care organization' has the meaning given that term in ORS 414.025; and

"(c) '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 International Classification of Disease or that is listed in the mental disorders section of the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

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

"(e) 'Substance use disorder treatment and services' means the treatment of and any 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 International Classification of Disease or that is listed in the substance use section of the current edition of the Diagnostic and Statistical Manual of

Mental Disorders.

"(2) Each coordinated care organization shall conduct an annual analysis of whether the processes, strategies, specific evidentiary standards or other factors the coordinated care organization used to design, determine applicability and apply each nonquantitative treatment limitation to behavioral health coverage 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 coordinated care organization used to design, determine applicability and apply each nonquantitative treatment limitation to medical and surgical coverage within the corresponding classification of benefits.

"(3) On or before March 1 of each year, each coordinated care organization shall report to the Oregon Health Authority, in the form and manner prescribed by the authority, the following information:

"(a) A description of the process the coordinated care organization used in developing and selecting the medical necessity criteria for behavioral health coverage and the process the coordinated care organization used in developing and selecting the medical necessity criteria for coverage of medical and surgical treatments.

"(b) A description of all nonquantitative treatment limitations that the coordinated care organization applies to behavioral health coverage and medical and surgical coverage.

"(c) The coordinated care organization's analysis of the processes, strategies, specific evidentiary standards or other factors that were used to design, determine applicability and apply the nonquantitative treatment limitations to behavioral health coverage compared to the coverage of medical and surgical treatments, including any factors that were considered and rejected.

"(d) The coordinated care organization's analysis in concluding that

the design and the processes, strategies, specific evidentiary standards or other factors that were used to design, determine applicability and apply the nonquantitative treatment limitations to behavioral health coverage were no more stringent than for the coverage of medical and surgical treatments.

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

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

"(g) The specific findings and conclusions in the coordinated care organization's analyses 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.

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

"(4) No later than September 15 of each calendar year, the authority, in collaboration with individuals representing behavioral health treatment providers, community mental health programs and consumers of mental health or substance use treatment, shall identify and assess the parity between the behavioral health coverage and the coverage of medical and surgical treatment in the medical assistance program and shall report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner pro-

1 **vided in ORS 192.245, the authority's findings on parity and an as-**
2 **sessment of:**
3 **"(a) The adequacy of the network of providers of behavioral health**
4 **treatment in providing timely access to mental health and substance**
5 **use treatment and services.**
6 **"(b) The criteria used by each coordinated care organization to de-**
7 **termine medical necessity and behavioral health coverage, including**
8 **each coordinated care organization's payment protocols and proce-**
9 **dures.**
10 **"(c) The consistency of credentialing requirements for behavioral**
11 **health treatment providers with the credentialing of medical and sur-**
12 **gical treatment providers.**
13 **"(d) The utilization review applied to behavioral health coverage**
14 **compared to coverage of medical and surgical treatments.**
15 **"SECTION 5.** ORS 414.766 is amended to read:
16 "414.766. **(1)** Notwithstanding ORS 414.065 and 414.690, a coordinated care
17 organization must provide behavioral health services to its members that
18 include but are not limited to all of the following:
19 "[*(1)*] **(a)** For a member who is experiencing a behavioral health crisis:
20 "[*(a)*] **(A)** A behavioral health assessment; and
21 "[*(b)*] **(B)** Services that are medically necessary to transition the member
22 to a lower level of care;
23 "[*(2)*] **(b)** At least the minimum level of services that are medically nec-
24 essary to treat a member's **underlying** behavioral health condition **rather**
25 **than a mere amelioration of current symptoms, such as suicidal**
26 **ideation or psychosis,** as determined in a behavioral health assessment of
27 the member or specified in the member's care plan; [*and*]
28 "**(c) Treatment of co-occurring behavioral health disorders or med-**
29 **ical conditions in a coordinated manner;**
30 **"(d) Treatment at the least intensive and least restrictive level of**

1 **care that is safe and effective and meets the needs of the individual's**
2 **condition;**
3 **"(e) A lower level or less intensive care only if it is safe and just**
4 **as effective as treatment at a higher level of service or intensity;**
5 **"(f) Treatment at a higher level of care when there is ambiguity as**
6 **to the appropriate level of care or when the recommended level of care**
7 **is not available;**
8 **"(g) Treatment to maintain functioning or prevent deterioration;**
9 **"(h) Treatment for an appropriate duration based on the**
10 **individual's particular needs;**
11 **"(i) Treatment appropriate to the unique needs of children and ad-**
12 **olescents;**
13 **"(j) Treatment appropriate to the unique needs of older adults; and**
14 "[*(3)*] **(k)** Coordinated care and case management as defined by the De-
15 partment of Consumer and Business Services by rule.
16 "**(2) A behavioral health treatment or service may not be subject**
17 **to prior authorization except as specifically permitted by the Oregon**
18 **Health Authority by rule.**
19 **"SECTION 6.** ORS 743A.168 is amended to read:
20 "743A.168. (1) As used in this section:
21 "(a) 'Behavioral health assessment' means an evaluation by a provider, in
22 person or using telemedicine, to determine a patient's need for behavioral
23 health treatment.
24 "(b) 'Behavioral health crisis' means a disruption in an [*individual's*]
25 **insured's** mental or emotional stability or functioning resulting in an urgent
26 need for immediate outpatient treatment in an emergency department or ad-
27 mission to a hospital to prevent a serious deterioration in the [*individual's*]
28 **insured's** mental or physical health.
29 "[*(c) 'Chemical dependency' means the addictive relationship with any drug*
30 *or alcohol characterized by a physical or psychological relationship, or both,*

that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, 'chemical dependency' does not include addiction to, or dependency on, tobacco, tobacco products or foods.]

"**(c) 'Behavioral health condition' means any condition or disorder that is:**

"(A) Within any of the diagnostic categories listed in the mental and behavioral chapters of the current edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems;

"(B) Listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders; or

"(C) Commonly understood to be a mental health or substance use disorder by health care providers practicing in the relevant clinical specialties.

"(d) 'Behavioral health treatment provider' includes a:

"(A) Psychiatrist.

"(B) Psychologist.

"(C) Licensed professional counselor.

"(D) Licensed marriage and family therapist.

"(E) Licensed clinical social worker.

"(F) Licensed nurse practitioner.

"(G) Physician.

"(H) Physician assistant.

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

"[*(e)*] **(f)** 'Group health insurer' means an insurer, **a third party administrator,** 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 all provider types during a calendar year.

"(h) 'Medically necessary' means clinically appropriate in the type, frequency, extent, siting and duration, based on generally accepted standards of care, to prevent, screen for, diagnose or manage an illness, injury or condition, including by controlling symptoms, maintaining a current level of functioning or preventing deterioration or relapse, at a level of care that is most effective to treat an individual patient's behavioral health condition and any co-occurring conditions.

"[*(f)*] **(i)** 'Prior authorization' has the meaning given that term in ORS 743B.001.

"[*(g)*] **(j)** 'Program' means a particular type or level of service that is organizationally distinct within a facility.

"[*(h)*] **(k)** 'Provider' means:

"(A) [*An individual*] **A behavioral health treatment provider** 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, is otherwise eligible to receive reimbursement for coverage under the policy [*and is a behavioral health professional or a medical professional licensed or certified in this state*];

"(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 [*(7)*] **(12)** of this section.

"[*(i)*] **(L)** 'Utilization review' has the meaning given that term in ORS 743B.001.

“**(m) ‘Treatment’ means a service, medication, item or other product prescribed or recommended by a treating provider to address a patient’s behavioral health condition or symptoms.**

“(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 [*for chemical dependency, including alcoholism, and for mental or nervous conditions*] 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 [*chemical dependency and for mental or nervous conditions*] **behavioral health treatment**:

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

“**(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 effective and meets the needs of the insured’s condition;

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

“(F) Treatment at a higher level of care when there is ambiguity as to the appropriate level of care or when the recommended level of care is not available;

“(G) Treatment to maintain functioning or prevent deterioration;

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

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

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

“[*(C)*] **(K)** 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 con-**

1 **ditions to short-term or acute behavioral health treatment at any level**
2 **of care or placement.**
3 **“(e) A group health insurer or an issuer of an individual health**
4 **benefit plan other than a grandfathered health plan shall have a net-**
5 **work of providers of behavioral health treatment sufficient to meet**
6 **the standards described in ORS 743B.505. If there is no in-network**
7 **provider qualified to timely deliver, as defined by rule, medically nec-**
8 **essary behavioral treatment to an insured in a geographic area, the**
9 **group health insurer or issuer of an individual health benefit plan**
10 **shall provide coverage of out-of-network services necessary for the**
11 **insured to have timely access to medically necessary behavioral health**
12 **treatment without any additional out-of-pocket costs.**
13 “[*(d)*] **(f)** A provider is eligible for reimbursement under this section if:
14 “(A) The provider is approved or certified by the Oregon Health Author-
15 ity;
16 “(B) The provider is accredited for the particular level of care for which
17 reimbursement is being requested by the Joint Commission or the Commis-
18 sion on Accreditation of Rehabilitation Facilities;
19 “(C) The patient is staying overnight at the facility and is involved in a
20 structured program at least eight hours per day, five days per week; or
21 “(D) The provider is providing a covered benefit under the policy.
22 “**(g) A group health insurer or an issuer of an individual health**
23 **benefit plan other than a grandfathered health plan must use the same**
24 **methodology to set reimbursement rates paid to behavioral health**
25 **treatment providers that the group health insurer or issuer of an in-**
26 **dividual health benefit plan uses to set reimbursement rates for med-**
27 **ical and surgical treatment providers.**
28 **“(h) A group health insurer or an issuer of an individual health**
29 **benefit plan other than a grandfathered health plan must update the**
30 **methodology and rates for reimbursing behavioral health treatment**

providers no less frequently than the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers.

"(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.

"[*(e)*] **(j)** [*If specified in the policy,*] Outpatient coverage **of behavioral health treatment** [*may*] **shall** include follow-up in-home service or outpatient services **if clinically indicated under 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 subsection (5) of this section**.

"[*(f)(A)*] **(k)(A)** Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer 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 approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers 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.

"[*(g)*] **(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) 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, either directly or by reference**, in accordance with this section**.

"**(5)(a) Any medical necessity or utilization 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) Standards of care and clinical practice that are generally recognized by health care providers practicing in the relevant clinical specialties such as psychiatry, psychology, clinical social work, addiction medicine and counseling and marriage and family therapy for the diagnosis, prevention and treatment of behavioral health conditions in children, adolescents and adults.

"(B) Valid, evidence-based sources such as peer-reviewed scientific studies and medical literature, the most recent versions of the treatment criteria or clinical practice guidelines and recommendations of nonprofit health care provider professional associations for the relevant specialty, specialty societies, agencies of the federal government and drug labeling approved by the United States Food and Drug Administration.

"(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 paragraph (a)(B) of this subsection; 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 paragraph (a)(B) this subsection.

"(6) To ensure the proper use of the criteria described in subsection (5) of this section, a group health insurer or an issuer of an individual health benefit plan shall:

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

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

"(c) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insureds.

"(d) Track, identify and analyze how the clinical review criteria are used to certify care, deny care and support the appeals process.

"(e) Conduct interrater reliability testing to ensure consistency in utilization review decision-making and medical necessity determinations. This assessment shall cover all aspects of utilization review.

"(f) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process.

"(g) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remedi-

1 **ation of poor interrater reliability and interrater reliability testing for**
2 **all new staff before they can determine medical necessity or conduct**
3 **utilization review without supervision.**

4 "[*(5)*] **(7)** This section does not prevent a group health insurer or issuer
5 of an individual health benefit plan that is not a grandfathered health plan
6 from contracting with providers of health care services to furnish services
7 to policyholders or certificate holders according to ORS 743B.460 or 750.005,
8 subject to the following conditions:

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

12 "(b) An insurer or health care service contractor shall, subject to sub-
13 section (2) of this section, pay benefits toward the covered charges of non-
14 contracting providers of services for [*the*] **behavioral** treatment [*of chemical*
15 *dependency or mental or nervous conditions*]. The insured shall, subject to
16 subsection (2) of this section, have the right to use the services of a non-
17 contracting provider of [*services for the*] **behavioral health** treatment [*of*
18 *chemical dependency or mental or nervous conditions*], whether or not the
19 [*services for chemical dependency or mental or nervous conditions are*] **be-**
20 **havioral health treatment is** provided by contracting or noncontracting
21 providers.

22 "[*(6)(a)*] **(8)(a)** This section does not require coverage for:

23 "(A) Educational or correctional services or sheltered living provided by
24 a school or halfway house;

25 "(B) A long-term residential mental health program that lasts longer than
26 45 days **unless clinically indicated under subsection (5) of this section**;

27 "(C) Psychoanalysis or psychotherapy received as part of an educational
28 or training program, regardless of diagnosis or symptoms that may be pres-
29 ent;

30 "(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) If a group health insurer, an issuer of an individual health benefit plan other than a grandfathered health plan or other individual described in subsection (2)(k) of this section authorizes a behavioral health treatment by a provider, the group health insurer, issuer of an individual health benefit plan or other individual may not rescind or modify the authorization, after the provider delivers the treatment in good faith and pursuant to the authorization, for any reason including but not limited to the subsequent rescission, cancellation or modification of the group health insurance policy or individual health benefit plan or the subsequent determination by the group health insurer, issuer of an individual health benefit plan or other individual that the group health insurer, issuer of an individual health benefit plan or other individual did not make an accurate determination of the insured's eligibility. This subsection does not expand or alter the coverage under the group health insurance policy or individual health benefit plan.**

"(10)(a) A group health insurance policy or individual health benefit plan may not contain a provision that reserves to the group health insurer or issuer of an individual health benefit plan other than a grandfathered health plan the sole authority to determine eligibility for benefits or coverage, to interpret the terms of the policy or plan or to provide standards of interpretation or review that are inconsistent with state law if the provision has the effect of conferring discretion on an insurer or issuer to determine entitlement to benefits or interpret terms and conditions that could lead a reviewing court to adopt a deferential standard of review.

"(b) Paragraph (a) of this subsection does not prohibit a provision that informs an insured that, as part of routine operations, the group health insurer, issuer of the individual health benefit plan or individual described in subsection (2)(k) of this section applies the terms and conditions of a group health insurance policy or individual health benefit plan in making determinations regarding eligibility or benefits or in explaining policies, procedures and processes as long as the provision could not give rise to a deferential standard of review by a reviewing court.

"(11) A group health insurer or issuer of an individual health benefit plan may not adopt, impose or enforce terms in policies or provider agreements, in writing or in practice, that undermine, alter or conflict with the requirements of this section.

"[*(7)*] **(12)** The Oregon Health Authority shall establish a process for the certification of an organization described in subsection [*(1)(h)(F)*] **(1)(k)(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.

"[*(8)*] **(13)** The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection [*(7)*] **(12)** of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

"[*(9)*] **(14)** 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 [*(7)*] **(12)** 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 [*(7)*] **(12)** of this section.

“[*(10)*] **(15)** 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 [*(7)*] **(12)** of this section to meet the insurer’s credentialing requirements as a condition of entering into a contract.

“[*(11)*] **(16)** 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:**

“(a) 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.

“(b) Update office visit billing codes for in-network medical providers at a greater frequency or greater percentage increase than office visit billing codes are updated for behavioral health treatment providers, based on the median maximum allowable reimbursement rates.

“(17) This section does not 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 patient for any unreimbursed cost of treatment.

“SECTION 7. ORS 743B.505 is amended to read:

“743B.505. (1) An insurer offering a [*health benefit plan*] **policy or certificate of health insurance** in this state that provides coverage to individuals or to small employers, as defined in ORS 743B.005, through a

1 specified network of health care providers shall:
2 "(a) Contract with or employ a network of providers that is sufficient in
3 number, geographic distribution and types of providers to ensure that all
4 covered services under the [*health benefit plan*] **policy or certificate of**
5 **health insurance**, including mental health and substance abuse treatment,
6 are accessible to enrollees **for initial and follow up appointments** without
7 unreasonable delay.
8 "(b)(A) With respect to **qualified** health [*benefit*] plans offered through
9 the health insurance exchange under ORS 741.310, contract with a sufficient
10 number and geographic distribution of essential community providers, where
11 available, to ensure reasonable and timely access to a broad range of essen-
12 tial community providers for low-income, medically underserved individuals
13 in the plan's service area in accordance with the network adequacy stan-
14 dards established by the Department of Consumer and Business Services;
15 "(B) If the **qualified** health [*benefit*] plan offered through the health in-
16 surance exchange offers a majority of the covered services through physi-
17 cians employed by the insurer or through a single contracted medical group,
18 have a sufficient number and geographic distribution of employed or con-
19 tracted providers and hospital facilities to ensure reasonable and timely ac-
20 cess for low-income, medically underserved enrollees in the plan's service
21 area, in accordance with network adequacy standards adopted by the De-
22 partment of Consumer and Business Services; or
23 "(C) With respect to health [*benefit*] **insurance** plans offered outside of
24 the health insurance exchange, contract with or employ a network of pro-
25 viders that is sufficient in number, geographic distribution and types of
26 providers to ensure access to care by enrollees who reside in locations within
27 the [*health benefit*] plan's service area that are designated by the Health
28 Resources and Services Administration of the United States Department of
29 Health and Human Services as health professional shortage areas or low-
30 income zip codes.

1 “(c) Annually report to the Department of Consumer and Business Ser-
2 vices, in the format prescribed by the department, the insurer’s [*plan for en-*
3 *suring that the*] network of providers for each health [*benefit*] **insurance**
4 plan [*meets the requirements of this section*].
5 “(2)(a) An insurer may not discriminate with respect to participation un-
6 der a health [*benefit*] **insurance** plan or coverage under the plan against any
7 health care provider who is acting within the scope of the provider’s license
8 or certification in this state.
9 “(b) This subsection does not require an insurer to contract with any
10 health care provider who is willing to abide by the insurer’s terms and con-
11 ditions for participation established by the insurer.
12 “(c) This subsection does not prevent an insurer from establishing varying
13 reimbursement rates based on quality or performance measures.
14 “(d) Rules adopted by the Department of Consumer and Business Services
15 to implement this section shall be consistent with the provisions of 42 U.S.C.
16 300gg-5 and the rules adopted by the United States Department of Health and
17 Human Services, the United States Department of the Treasury or the United
18 States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect
19 on January 1, 2017.
20 “(3) The Department of Consumer and Business Services shall use one of
21 the following methods in [*evaluating*] **an annual evaluation of** whether the
22 network of providers available to enrollees in a health [*benefit*] **insurance**
23 plan meets the requirements of this section:
24 “(a) An approach by which an insurer submits evidence that the insurer
25 is complying with at least one of the factors prescribed by the department
26 by rule from each of the following categories:
27 “(A) Access to care consistent with the needs of the enrollees served by
28 the network;
29 “(B) Consumer satisfaction;
30 “(C) Transparency; and

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

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

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

"(a) An adequate number and geographic distribution of licensed professional counselors, licensed marriage and family therapists, licensed clinical social workers, psychologists and psychiatrists who are accepting new patients, based on the needs of the insureds under the policy or certificate including but not limited to providers who can address the needs of:

"(A) Children and adults;

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

"(C) Individuals with diverse cultural or ethnic backgrounds;

"(D) Individuals with chronic or complex behavioral health conditions;

"(E) Other groups specified by the department by rule;

"(b) An adequate number of the providers described in paragraph (a) of this subsection in all geographic areas where the insurer offers plans; and

"(c) Providers from communities represented by the enrollees in the plans offered by the insurer, including:

"(A) Providers from the lesbian, gay, bisexual, transgender and queer communities;

"(B) Providers who are Black, indigenous or other people of color; and

"(C) Providers who are the same gender as and providers who speak

1 **the preferred languages of the enrollees in the plans offered by the**
2 **insurer.**
3 "[*(4)*] **(5)** This section does not require an insurer to contract with an
4 essential community provider that refuses to accept the insurer's generally
5 applicable payment rates for services covered by the plan.
6 "[*(5)*] **(6)** This section does not require an insurer to submit provider
7 contracts to the department for review.".
8