

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) ‘Carrier’ has the meaning given that term in ORS 743B.005.**

12 **“(c) ‘Geographic region’ means the geographic area of the state**  
13 **established by the Department of Consumer and Business Services for**  
14 **the purpose of determining geographic average rates, as defined in**  
15 **ORS 743B.005.**

16 **“(d) ‘Health benefit plan’ has the meaning given that term in ORS**  
17 **743B.005.**

18 **“(e) ‘Median maximum allowable reimbursement rate’ means the**  
19 **median of all maximum allowable reimbursement rates, minus incen-**  
20 **tive payments, paid for each billing code for each provider type during**  
21 **a calendar year.**

1       “(f) ‘Mental health treatment and services’ means the treatment  
2 of or services provided to address any condition or disorder that falls  
3 under any of the diagnostic categories listed in the mental disorders  
4 section of the current edition of the International Classification of  
5 Disease or that is listed in the mental disorders section of the current  
6 edition of the Diagnostic and Statistical Manual of Mental Disorders.

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

10       “(h) ‘Substance use disorder treatment and services’ means the  
11 treatment of or services provided to address any condition or disorder  
12 that falls under any of the diagnostic categories listed in the substance  
13 use section of the current edition of the International Classification  
14 of Disease or that is listed in the substance use section of the current  
15 edition of the Diagnostic and Statistical Manual of Mental Disorders.

16       “(2) Each carrier that offers an individual or group health benefit  
17 plan in this state that provides behavioral health benefits shall con-  
18 duct an annual analysis of whether the processes, strategies, specific  
19 evidentiary standards or other factors the carrier used to design, de-  
20 termine applicability of and apply each nonquantitative treatment  
21 limitation to behavioral health benefits within each classification of  
22 benefits are comparable to, and are applied no more stringently than,  
23 the processes, strategies, specific evidentiary standards or other fac-  
24 tors the carrier used to design, determine applicability of and apply  
25 each nonquantitative treatment limitation to medical and surgical  
26 benefits within the corresponding classification of benefits.

27       “(3) On or before March 1 of each year, all carriers that offer indi-  
28 vidual or group health benefit plans in this state that provide behav-  
29 ioral health benefits shall report to the Department of Consumer and  
30 Business Services, in the form and manner prescribed by the depart-

1 **ment, the following information:**

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

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

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

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

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

29 **“(f) The number of denials of behavioral health benefits and medical**  
30 **and surgical benefits, the percentage of denials that were appealed, the**

1 percentage of appeals that upheld the denial and the percentage of  
2 appeals that overturned the denial.

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

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

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

13 “(A) Psychiatrists.

14 “(B) Psychiatric mental health nurse practitioners.

15 “(C) Psychologists.

16 “(D) Licensed clinical social workers.

17 “(E) Licensed professional counselors.

18 “(F) Licensed marriage and family therapists.

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

22 “(A) Physicians.

23 “(B) Physician assistants.

24 “(C) Licensed nurse practitioners.

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

30 “(L) Other data or information the department deems necessary to

1 assess a carrier's compliance with mental health parity requirements.

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

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

11 **“(a) ‘Behavioral health coverage’ means mental health treatment**  
12 **and services and substance use disorder treatment or services reim-**  
13 **bursed by a coordinated care organization.**

14 **“(b) ‘Coordinated care organization’ has the meaning given that**  
15 **term in ORS 414.025.**

16 **“(c) ‘Mental health treatment and services’ means the treatment**  
17 **of or services provided to address any condition or disorder that falls**  
18 **under any of the diagnostic categories listed in the mental disorders**  
19 **section of the current edition of the International Classification of**  
20 **Disease or that is listed in the mental disorders section of the current**  
21 **edition of the Diagnostic and Statistical Manual of Mental Disorders.**

22 **“(d) ‘Nonquantitative treatment limitation’ means a limitation that**  
23 **is not expressed numerically but otherwise limits the scope or duration**  
24 **of behavioral health coverage, such as medical necessity criteria or**  
25 **other utilization review.**

26 **“(e) ‘Substance use disorder treatment and services’ means the**  
27 **treatment of and any services provided to address any condition or**  
28 **disorder that falls under any of the diagnostic categories listed in the**  
29 **substance use section of the current edition of the International**  
30 **Classification of Disease or that is listed in the substance use section**

1 of the current edition of the Diagnostic and Statistical Manual of  
2 Mental Disorders.

3 “(2) On or before June 1 of each year, each coordinated care or-  
4 ganization shall report to the Oregon Health Authority information  
5 about the coordinated care organization’s compliance with mental  
6 health parity requirements, including but not limited to the following:

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

12 “(b) The factors used to determine that the nonquantitative treat-  
13 ment limitations will apply to mental health or substance use disorder  
14 benefits and medical or surgical benefits.

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

21 “(d) The number of denials of coverage of mental health treatment  
22 and services, substance use disorder treatment and services and med-  
23 ical and surgical treatment and services, the percentage of denials that  
24 were appealed, the percentage of appeals that upheld the denial and  
25 the percentage of appeals that overturned the denial.

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

30 “(f) Other data or information the authority deems necessary to

1 assess a coordinated care organization's compliance with mental  
2 health parity requirements.

3 “(3) Coordinated care organizations must demonstrate in the doc-  
4 umentation submitted under subsection (2) of this section, that the  
5 processes, strategies, evidentiary standards and other factors used to  
6 apply nonquantitative treatment limitation to mental health or sub-  
7 stance use disorder treatment, as written and in operation, are com-  
8 parable to and are applied no more stringently than the processes,  
9 strategies, evidentiary standards and other factors used to apply non-  
10 quantitative treatment limitations to medical or surgical treatments  
11 in the same classification.

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

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

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

29 “(c) The criteria used by each coordinated care organization to de-  
30 termine medical necessity and behavioral health coverage, including

1 each coordinated care organization’s payment protocols and proce-  
2 dures.

3 “(d) The consistency of credentialing requirements for behavioral  
4 health treatment providers with the credentialing of medical and sur-  
5 gical treatment providers.

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

8 “(f) The specific findings and conclusions reached by the authority  
9 with respect to the coverage of mental health and substance use dis-  
10 order treatment and the authority’s analysis that indicates that the  
11 coverage is or is not in compliance with this section.

12 “(g) The specific findings and conclusions of the authority demon-  
13 strating a coordinated care organization’s compliance with this section  
14 and with the Paul Wellstone and Pete Domenici Mental Health Parity  
15 and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted  
16 thereunder.

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

18 “414.766. (1) Notwithstanding ORS 414.065 and 414.690, a coordinated care  
19 organization must provide behavioral health services to its members that  
20 include but are not limited to all of the following:

21 “[1] (a) For a member who is experiencing a behavioral health crisis:

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

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

25 “[2] (b) At least the minimum level of services that are medically nec-  
26 essary to treat a member’s **underlying** behavioral health condition **rather**  
27 **than a mere amelioration of current symptoms, such as suicidal**  
28 **ideation or psychosis**, as determined in a behavioral health assessment of  
29 the member or specified in the member’s care plan; [and]

30 “(c) Treatment of co-occurring behavioral health disorders or med-



1 ical conditions in a coordinated manner;

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

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

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

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

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

13 “(i) Treatment appropriate to the unique needs of children and ad-  
14 olescents;

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

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

17 “(L) Treatment that is appropriate to the unique needs of gay,  
18 lesbian, bisexual and transgender individuals and individuals of any  
19 other minority gender identity or sexual orientation; and

20 “[3] (m) Coordinated care and case management as defined by the De-  
21 partment of Consumer and Business Services by rule.

22 “(2) If there is a disagreement about the level of care required by  
23 subsection (1)(e) or (f) of this subsection, a coordinated care organ-  
24 ization shall provide to the behavioral health treatment provider full  
25 details of the coordinated care organization’s scoring or assessment  
26 using the relevant level of care placement criteria and guidelines.

27 “(3) The Oregon Health Authority shall adopt by rule a list of be-  
28 havioral health services that may not be subject to prior authori-  
29 zation.

30 “SECTION 5. ORS 743A.168 is amended to read:

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

2 “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in  
3 person or using telemedicine, to determine a patient’s need for behavioral  
4 health treatment.

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

7 “[~~(b)~~] (c) ‘Behavioral health crisis’ means a disruption in an  
8 [~~individual’s~~] **insured’s** mental or emotional stability or functioning result-  
9 ing in an urgent need for immediate outpatient treatment in an emergency  
10 department or admission to a hospital to prevent a serious deterioration in  
11 the [~~individual’s~~] **insured’s** mental or physical health.

12 “[~~(c)~~] *‘Chemical dependency’ means the addictive relationship with any drug  
13 or alcohol characterized by a physical or psychological relationship, or both,  
14 that interferes on a recurring basis with the individual’s social, psychological  
15 or physical adjustment to common problems. For purposes of this section,  
16 ‘chemical dependency’ does not include addiction to, or dependency on, tobacco,  
17 tobacco products or foods.*]

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

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

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

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

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

26 “(B) **Products and services that:**

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

30 “(ii) **Are clinically appropriate in terms of type, frequency, extent,**

1 **site and duration; and**

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

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

7 **“(g) ‘Median maximum allowable reimbursement rate’ means the**  
8 **median of all maximum allowable reimbursement rates, minus incen-**  
9 **tive payments, paid for each billing code for each provider type during**  
10 **a calendar year.**

11 “[*f*] (h) ‘Prior authorization’ has the meaning given that term in ORS  
12 743B.001.

13 “[*g*] (i) ‘Program’ means a particular type or level of service that is or-  
14 ganizationally distinct within a facility.

15 “[*h*] (j) ‘Provider’ means:

16 **“(A) [*An individual*] A behavioral health professional or medical**  
17 **professional licensed or certified in this state** who has met the creden-  
18 tialing requirement of a group health insurer or an issuer of an individual  
19 health benefit plan that is not a grandfathered health plan as defined in ORS  
20 743B.005[,] **and** is otherwise eligible to receive reimbursement for coverage  
21 under the policy [*and is a behavioral health professional or a medical profes-*  
22 *sional licensed or certified in this state*];

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

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

25 **“(D) A day or partial hospitalization program;**

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

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

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

30 **“(A) Psychiatry;**

1       **“(B) Psychology;**  
2       **“(C) Clinical sociology;**  
3       **“(D) Addiction medicine and counseling; and**  
4       **“(E) Behavioral health treatment.**

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

7       **“(A) Patient placement criteria;**  
8       **“(B) Recommendations of agencies of the federal government; and**  
9       **“(C) Drug labeling approved by the United States Food and Drug**  
10 **Administration.**

11       **“[(i)] (m) ‘Utilization review’ has the meaning given that term in ORS**  
12 **743B.001.**

13       **“(n) ‘Valid, evidence-based sources’ includes but is not limited to:**  
14       **“(A) Peer-reviewed scientific studies and medical literature;**  
15       **“(B) Recommendations of nonprofit health care provider profes-**  
16 **sional associations; and**  
17       **“(C) Specialty societies.**

18       **“(2) A group health insurance policy or an individual health benefit plan**  
19 **that is not a grandfathered health plan providing coverage for hospital or**  
20 **medical expenses, other than limited benefit coverage, shall provide coverage**  
21 **for expenses arising from the diagnosis of **behavioral health conditions** and**  
22 **medically necessary behavioral health treatment [for chemical dependency,**  
23 **including alcoholism, and for mental or nervous conditions] at the same level**  
24 **as, and subject to limitations no more restrictive than, those imposed on**  
25 **coverage or reimbursement of expenses arising from treatment for other**  
26 **medical conditions. The following apply to coverage for [chemical dependency**  
27 **and for mental or nervous conditions] **behavioral health treatment:****

28       **“(a) The coverage may be made subject to provisions of the policy that**  
29 **apply **equally** to **all** other benefits under the policy, including but not lim-**  
30 **ited to provisions relating to **copayments**, deductibles and coinsurance.**

1 **Copayments**, deductibles and coinsurance for treatment in health care fa-  
2 cilities or residential facilities may not be greater than those under the  
3 policy for expenses of hospitalization in the treatment of other medical con-  
4 ditions. **Copayments**, deductibles and coinsurance for outpatient treatment  
5 may not be greater than those under the policy for expenses of outpatient  
6 treatment of other medical conditions.

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

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

16 “(A) A behavioral health assessment;

17 “(B) No less than the level of services determined to be medically neces-  
18 sary in a behavioral health assessment of **the specific needs of** a patient  
19 or in a patient’s care plan:

20 “(i) To **effectively** treat the patient’s **underlying** behavioral health con-  
21 dition **rather than the mere amelioration of current symptoms such**  
22 **as suicidal ideation or psychosis**; and

23 “(ii) For care following a behavioral health crisis, to transition the pa-  
24 tient to a lower level of care; *[and]*

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

27 “(D) **Treatment at the least intensive and least restrictive level of**  
28 **care that is safe and most effective and meets the needs of the**  
29 **insured’s condition**;

30 “(E) **A lower level or less intensive care only if it is comparably as**

1 **safe and effective as treatment at a higher level of service or intensity;**

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

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

5 **“(H) Treatment appropriate to the unique needs of children and**  
6 **adolescents;**

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

8 **“[(C)] (J) Coordinated care and case management as defined by the De-**  
9 **partment of Consumer and Business Services by rule.**

10 **“(d) The coverage of behavioral health treatment may not limit**  
11 **coverage for treatment of pervasive or chronic behavioral health con-**  
12 **ditions to short-term or acute behavioral health treatment at any level**  
13 **of care or placement.**

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

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

26 **“(A) The provider is approved or certified by the Oregon Health Author-**  
27 **ity;**

28 **“(B) The provider is accredited for the particular level of care for which**  
29 **reimbursement is being requested by the Joint Commission or the Commis-**  
30 **sion on Accreditation of Rehabilitation Facilities;**

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

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

4 “(g) **A group health insurer or an issuer of an individual health**  
5 **benefit plan other than a grandfathered health plan must use the same**  
6 **methodology to set reimbursement rates paid to behavioral health**  
7 **treatment providers that the group health insurer or issuer of an in-**  
8 **dividual health benefit plan uses to set reimbursement rates for med-**  
9 **ical and surgical treatment providers.**

10 “(h) **A group health insurer or an issuer of an individual health**  
11 **benefit plan other than a grandfathered health plan must update the**  
12 **methodology and rates for reimbursing behavioral health treatment**  
13 **providers no less frequently than the group health insurer or issuer**  
14 **of an individual health benefit plan updates the methodology and rates**  
15 **for reimbursing medical and surgical treatment providers, unless oth-**  
16 **erwise required by federal law.**

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

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

1 **necessity, utilization or other clinical review conducted for the diag-**  
2 **nosis, prevention or treatment of behavioral health conditions or re-**  
3 **lating to service intensity, level of care placement, continued stay or**  
4 **discharge.**

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

18 “(B) Review shall be made according to criteria made available to pro-  
19 viders in advance upon request.

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

28 “(D) Review may involve prior approval, concurrent review of the con-  
29 tinuation of treatment, post-treatment review or any combination of these.  
30 However, if prior approval is required, provision shall be made to allow for



1 payment of urgent or emergency admissions, subject to subsequent review.  
2 If prior approval is not required, group health insurers and issuers of indi-  
3 vidual health benefit plans that are not grandfathered health plans shall  
4 permit providers, policyholders or persons acting on their behalf to make  
5 advance inquiries regarding the appropriateness of a particular admission to  
6 a treatment program. Group health insurers and issuers of individual health  
7 benefit plans that are not grandfathered health plans shall provide a timely  
8 response to such inquiries. Noncontracting providers must cooperate with  
9 these procedures to the same extent as contracting providers to be eligible  
10 for reimbursement.

11 “[g)] (L) Health maintenance organizations may limit the receipt of  
12 covered services by enrollees to services provided by or upon referral by  
13 providers contracting with the health maintenance organization. Health  
14 maintenance organizations and health care service contractors may create  
15 substantive plan benefit and reimbursement differentials at the same level  
16 as, and subject to limitations no more restrictive than, those imposed on  
17 coverage or reimbursement of expenses arising out of other medical condi-  
18 tions and apply them to contracting and noncontracting providers.

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

27 “(4) The Legislative Assembly finds that health care cost containment is  
28 necessary and intends to encourage health insurance plans designed to  
29 achieve cost containment by ensuring that reimbursement is limited to ap-  
30 propriate utilization under criteria incorporated into the insurance, either

1 directly or by reference, **in accordance with this section.**

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

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

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

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

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

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

25 **“(b) An insurer or health care service contractor shall, subject to sub-**  
26 **section (2) of this section, pay benefits toward the covered charges of non-**  
27 **contracting providers of services for [the] behavioral health treatment [of**  
28 **chemical dependency or mental or nervous conditions]. The insured shall,**  
29 **subject to subsection (2) of this section, have the right to use the services**  
30 **of a noncontracting provider of [services for the] behavioral health treat-**

1 ment [*of chemical dependency or mental or nervous conditions*], whether or  
2 not the [*services for chemical dependency or mental or nervous conditions*  
3 *are*] **behavioral health treatment is** provided by contracting or noncon-  
4 tracting providers.

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

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

8 “(B) A long-term residential mental health program that lasts longer than  
9 45 days **unless clinically indicated under any medical necessity, utili-**  
10 **zation or other clinical review conducted by the insurer for the diag-**  
11 **nosis, prevention or treatment of behavioral health conditions or**  
12 **relating to service intensity, level of care placement, continued stay**  
13 **or discharge;**

14 “(C) Psychoanalysis or psychotherapy received as part of an educational  
15 or training program, regardless of diagnosis or symptoms that may be pres-  
16 ent;

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

18 “(E) Support groups.

19 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may  
20 receive covered outpatient services under the terms of the insured’s policy  
21 while the insured is living temporarily in a sheltered living situation.

22 “[~~(7)~~] **(8)** The Oregon Health Authority shall establish a process for the  
23 certification of an organization described in subsection [~~(1)(h)(F)~~] **(1)(j)(F)**  
24 of this section that:

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

27 “(b) Does not contract with the authority, a subcontractor of the author-  
28 ity or a community mental health program.

29 “[~~(8)~~] **(9)** The Oregon Health Authority shall adopt by rule standards for  
30 the certification provided under subsection [~~(7)~~] **(8)** of this section to ensure

1 that a certified provider organization offers a distinct and specialized pro-  
2 gram for the treatment of mental or nervous conditions.

3 “[9] (10) The Oregon Health Authority may adopt by rule an application  
4 fee or a certification fee, or both, to be imposed on any provider organization  
5 that applies for certification under subsection [(7)] (8) of this section. Any  
6 fees collected shall be paid into the Oregon Health Authority Fund estab-  
7 lished in ORS 413.101 and shall be used only for carrying out the provisions  
8 of subsection [(7)] (8) of this section.

9 “[10] (11) The intent of the Legislative Assembly in adopting this section  
10 is to reserve benefits for different types of care to encourage cost effective  
11 care and to ensure continuing access to levels of care most appropriate for  
12 the insured’s condition and progress **in accordance with this section**. This  
13 section does not prohibit an insurer from requiring a provider organization  
14 certified by the Oregon Health Authority under subsection [(7)] (8) of this  
15 section to meet the insurer’s credentialing requirements as a condition of  
16 entering into a contract.

17 “[11] (12) The Director of the Department of Consumer and Business  
18 Services and the Oregon Health Authority, after notice and hearing, may  
19 adopt reasonable rules not inconsistent with this section that are considered  
20 necessary for the proper administration of this section. **The director shall**  
21 **adopt rules making it a violation of this section for a group health**  
22 **insurer or issuer of an individual health benefit plan other than a**  
23 **grandfathered health plan to require providers to bill using a specific**  
24 **billing code or to restrict the reimbursement paid for particular billing**  
25 **codes other than on the basis of medical necessity.**

26 “(13) This section does not:

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

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

4       **“(c) Require that any value-based payment method reimburse be-**  
5 **havioral health services based on an equivalent fee-for-service rate.**

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

7       **“743B.505. (1) An insurer offering a health benefit plan in this state that**  
8 **provides coverage to individuals or to small employers, as defined in ORS**  
9 **743B.005, through a specified network of health care providers shall:**

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

15       **“(b)(A) With respect to health benefit plans offered through the health**  
16 **insurance exchange under ORS 741.310, contract with a sufficient number**  
17 **and geographic distribution of essential community providers, where avail-**  
18 **able, to ensure reasonable and timely access to a broad range of essential**  
19 **community providers for low-income, medically underserved individuals in**  
20 **the plan’s service area in accordance with the network adequacy standards**  
21 **established by the Department of Consumer and Business Services;**

22       **“(B) If the health benefit plan offered through the health insurance ex-**  
23 **change offers a majority of the covered services through physicians employed**  
24 **by the insurer or through a single contracted medical group, have a suffi-**  
25 **cient number and geographic distribution of employed or contracted provid-**  
26 **ers and hospital facilities to ensure reasonable and timely access for**  
27 **low-income, medically underserved enrollees in the plan’s service area, in**  
28 **accordance with network adequacy standards adopted by the Department of**  
29 **Consumer and Business Services; or**

30       **“(C) With respect to health benefit plans offered outside of the health**

1 insurance exchange, contract with or employ a network of providers that is  
2 sufficient in number, geographic distribution and types of providers to ensure  
3 access to care by enrollees who reside in locations within the health benefit  
4 plan's service area that are designated by the Health Resources and Services  
5 Administration of the United States Department of Health and Human Ser-  
6 vices as health professional shortage areas or low-income zip codes.

7 “(c) Annually report to the Department of Consumer and Business Ser-  
8 vices, in the format prescribed by the department, the insurer's [*plan for en-*  
9 *surving that the*] network of providers for each health benefit plan [*meets the*  
10 *requirements of this section*].

11 “(2)(a) An insurer may not discriminate with respect to participation un-  
12 der a health benefit plan or coverage under the plan against any health care  
13 provider who is acting within the scope of the provider's license or certi-  
14 fication in this state.

15 “(b) This subsection does not require an insurer to contract with any  
16 health care provider who is willing to abide by the insurer's terms and con-  
17 ditions for participation established by the insurer.

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

20 “(d) Rules adopted by the Department of Consumer and Business Services  
21 to implement this section shall be consistent with the provisions of 42 U.S.C.  
22 300gg-5 and the rules adopted by the United States Department of Health and  
23 Human Services, the United States Department of the Treasury or the United  
24 States Department of Labor to carry out 42 U.S.C. 300gg-5 that are in effect  
25 on January 1, 2017.

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

30 “(a) An approach by which an insurer submits evidence that the insurer

1 is complying with at least one of the factors prescribed by the department  
2 by rule from each of the following categories:

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

5 “(B) Consumer satisfaction;

6 “(C) Transparency; and

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

8 “(b) A nationally recognized standard adopted by the department and ad-  
9 justed, as necessary, to reflect the age demographics of the enrollees in the  
10 plan.

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

14 **“(a) An adequate number and geographic distribution, as prescribed**  
15 **by the department by rule, of licensed professional counselors, licensed**  
16 **marriage and family therapists, licensed clinical social workers, psy-**  
17 **chologists and psychiatrists who are accepting new patients, based on**  
18 **the needs of the insureds under the policy or certificate, including but**  
19 **not limited to providers who can address the needs of:**

20 **“(A) Children and adults;**

21 **“(B) Individuals with limited English proficiency or who are illiter-**  
22 **ate;**

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

24 **“(D) Individuals with chronic or complex behavioral health condi-**  
25 **tions; and**

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

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

30 **“[(4)] (5) This section does not require an insurer to contract with an**

1 essential community provider that refuses to accept the insurer’s generally  
2 applicable payment rates for services covered by the plan.

3 “[5] (6) This section does not require an insurer to submit provider  
4 contracts to the department for review.”.

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

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

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

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

11 “(c) ‘Geographic region’ means the geographic area of the state estab-  
12 lished by the Department of Consumer and Business Services for the purpose  
13 of determining geographic average rates, as defined in ORS 743B.005.

14 “(d) ‘Health benefit plan’ has the meaning given that term in ORS  
15 743B.005.

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

19 “(f) ‘Mental health treatment and services’ means the treatment of or  
20 services provided to address any condition or disorder that falls under any  
21 of the diagnostic categories listed in the mental disorders section of the  
22 current edition of the International Classification of Disease or that is listed  
23 in the mental disorders section of the current edition of the Diagnostic and  
24 Statistical Manual of Mental Disorders.

25 “(g) ‘Nonquantitative treatment limitation’ means a limitation that is not  
26 expressed numerically but otherwise limits the scope or duration of behav-  
27 ioral health benefits.

28 “(h) ‘Substance use disorder treatment and services’ means the treatment  
29 of or services provided to address any condition or disorder that falls under  
30 any of the diagnostic categories listed in the substance use section of the



1 current edition of the International Classification of Disease or that is listed  
2 in the substance use section of the current edition of the Diagnostic and  
3 Statistical Manual of Mental Disorders.

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

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

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

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

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

1 “(d) The comparative analyses demonstrating that the processes, strate-  
2 gies, evidentiary standards and other factors used to apply the nonquantita-  
3 tive treatment limitations to mental health or substance use disorder  
4 benefits, as written and in operation, are comparable to, and are applied no  
5 more stringently than, the processes, strategies, evidentiary standards and  
6 other factors used to apply the nonquantitative treatment limitations to  
7 medical or surgical benefits in the benefits classification.

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

12 “[*f*] *The number of denials of behavioral health benefits and medical and*  
13 *surgical benefits, the percentage of denials that were appealed, the percentage*  
14 *of appeals that upheld the denial and the percentage of appeals that overturned*  
15 *the denial.*]

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

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

22 “[*i*] *The reimbursement rate in each geographic region for a time-based*  
23 *office visit and the percentage of the Medicare rate the reimbursement rate*  
24 *represents, paid to:*]

25 “[*A*] *Psychiatrists.*]

26 “[*B*] *Psychiatric mental health nurse practitioners.*]

27 “[*C*] *Psychologists.*]

28 “[*D*] *Licensed clinical social workers.*]

29 “[*E*] *Licensed professional counselors.*]

30 “[*F*] *Licensed marriage and family therapists.*]

1       “[(j) *The reimbursement rate in each geographic region for a time-based*  
2 *office visit and the percentage of the Medicare rate the reimbursement rate*  
3 *represents, paid to:]*

4       “[(A) *Physicians.*]

5       “[(B) *Physician assistants.*]

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

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

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

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

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

22       “743A.168. (1) As used in this section:

23       “(a) ‘Behavioral health assessment’ means an evaluation by a provider, in  
24 person or using telemedicine, to determine a patient’s need for behavioral  
25 health treatment.

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

28       “(c) ‘Behavioral health crisis’ means a disruption in an insured’s mental  
29 or emotional stability or functioning resulting in an urgent need for imme-  
30 diate outpatient treatment in an emergency department or admission to a

1 hospital to prevent a serious deterioration in the insured's mental or phys-  
2 ical health.

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

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

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

7 “(i) Are generally recognized by health care providers practicing in rele-  
8 vant clinical specialties; and

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

10 “(B) Products and services that:

11 “(i) Address the specific needs of a patient for the purpose of screening  
12 for, preventing, diagnosing, managing or treating an illness, injury or con-  
13 dition or symptoms of an illness, injury or condition;

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

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

19 “(f) ‘Group health insurer’ means an insurer, a health maintenance or-  
20 ganization or a health care service contractor.

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

24 “(h) ‘Prior authorization’ has the meaning given that term in ORS  
25 743B.001.

26 “(i) ‘Program’ means a particular type or level of service that is organ-  
27 izationally distinct within a facility.

28 “(j) ‘Provider’ means:

29 “(A) A behavioral health professional or medical professional licensed or  
30 certified in this state who has met the credentialing requirement of a group

1 health insurer or an issuer of an individual health benefit plan that is not  
2 a grandfathered health plan as defined in ORS 743B.005 and is otherwise el-  
3 igible to receive reimbursement for coverage under the policy;

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

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

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

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

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

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

11 “(A) Psychiatry;

12 “(B) Psychology;

13 “(C) Clinical sociology;

14 “(D) Addiction medicine and counseling; and

15 “(E) Behavioral health treatment.

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

18 “(A) Patient placement criteria;

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

20 “(C) Drug labeling approved by the United States Food and Drug Ad-  
21 ministration.

22 “(m) ‘Utilization review’ has the meaning given that term in ORS  
23 743B.001.

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

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

26 “(B) Recommendations of nonprofit health care provider professional as-  
27 sociations; and

28 “(C) Specialty societies.

29 “(2) A group health insurance policy or an individual health benefit plan  
30 that is not a grandfathered health plan providing coverage for hospital or

1 medical expenses, other than limited benefit coverage, shall provide coverage  
2 for expenses arising from the diagnosis of behavioral health conditions and  
3 medically necessary behavioral health treatment at the same level as, and  
4 subject to limitations no more restrictive than, those imposed on coverage  
5 or reimbursement of expenses arising from treatment for other medical con-  
6 ditions. The following apply to coverage for behavioral health treatment:

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

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

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

25 “(A) A behavioral health assessment;

26 “(B) No less than the level of services determined to be medically neces-  
27 sary in a behavioral health assessment of the specific needs of a patient or  
28 in a patient’s care plan:

29 “(i) To effectively treat the patient’s underlying behavioral health condi-  
30 tion rather than the mere amelioration of current symptoms such as suicidal

1 ideation or psychosis; and

2 “(ii) For care following a behavioral health crisis, to transition the pa-  
3 tient to a lower level of care;

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

6 “(D) Treatment at the least intensive and least restrictive level of care  
7 that is safe and most effective and meets the needs of the insured’s condition;

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

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

11 “(G) Treatment for an appropriate duration based on the insured’s par-  
12 ticular needs;

13 “(H) Treatment appropriate to the unique needs of children and adoles-  
14 cents;

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

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

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

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

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

2 “(A) The provider is approved or certified by the Oregon Health Author-  
3 ity;

4 “(B) The provider is accredited for the particular level of care for which  
5 reimbursement is being requested by the Joint Commission or the Commis-  
6 sion on Accreditation of Rehabilitation Facilities;

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

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

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

15 “(h) A group health insurer or an issuer of an individual health benefit  
16 plan other than a grandfathered health plan must update the methodology  
17 and rates for reimbursing behavioral health treatment providers no less fre-  
18 quently than the group health insurer or issuer of an individual health ben-  
19 efit plan updates the methodology and rates for reimbursing medical and  
20 surgical treatment providers, unless otherwise required by federal law.

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

26 “(j) Outpatient coverage of behavioral health treatment shall include  
27 follow-up in-home service or outpatient services if clinically indicated under  
28 *[any medical necessity, utilization or other clinical review conducted for the*  
29 *diagnosis, prevention or treatment of behavioral health conditions or relating*  
30 *to service intensity, level of care placement, continued stay or discharge]* **cri-**



1 **teria and guidelines described in subsection (5) of this section.** The  
2 policy may limit coverage for in-home service to persons who are homebound  
3 under the care of a physician only if clinically indicated under [*any medical*  
4 *necessity, utilization or other clinical review conducted for the diagnosis, pre-*  
5 *vention or treatment of behavioral health conditions or relating to service in-*  
6 *tensity, level of care placement, continued stay or discharge*] **criteria and**  
7 **guidelines described in subsection (5) of this section.**

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

21 “(B) Review shall be made according to criteria made available to pro-  
22 viders in advance upon request.

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

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

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

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

30      “(4) The Legislative Assembly finds that health care cost containment is

1 necessary and intends to encourage health insurance plans designed to  
2 achieve cost containment by ensuring that reimbursement is limited to ap-  
3 propriate utilization under criteria incorporated into the insurance, either  
4 directly or by reference, in accordance with this section.

5 **“(5)(a) Any medical necessity, utilization or other clinical review**  
6 **conducted for the diagnosis, prevention or treatment of behavioral**  
7 **health conditions or relating to service intensity, level of care place-**  
8 **ment, continued stay or discharge must be based solely on the fol-**  
9 **lowing:**

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

11 **“(B) The most recent version of the levels of care placement criteria**  
12 **and practice guidelines developed by the nonprofit professional asso-**  
13 **ciation for the relevant clinical specialty.**

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

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

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

25 **“(c) For all level of care placement decisions, an insurer shall au-**  
26 **thorize placement at the level of care consistent with the insured’s**  
27 **score or assessment using the relevant level of care placement criteria**  
28 **and guidelines as specified in paragraph (a)(B) of this subsection. If**  
29 **the level of care indicated by the criteria and guidelines is not avail-**  
30 **able, the insurer shall authorize the next higher level of care. If there**

1 **is disagreement about the appropriate level of care, the insurer shall**  
2 **provide to the provider of the service the full details of the insurer’s**  
3 **scoring or assessment using the relevant level of care placement cri-**  
4 **teria and guidelines specified in paragraph (a)(B) of this subsection.**

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

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

14 “(b) Make the education program available to other stakeholders, includ-  
15 ing participating providers and insureds. Participating providers shall not  
16 be required to participate in the education program.

17 “(c) Provide, at no cost, the *[medical necessity, utilization or other clinical*  
18 *review criteria]* **criteria and guidelines described in subsection (5) of this**  
19 **section** and any training material or resources to providers and insureds.

20 “[6] (7) This section does not prevent a group health insurer or issuer  
21 of an individual health benefit plan that is not a grandfathered health plan  
22 from contracting with providers of health care services to furnish services  
23 to policyholders or certificate holders according to ORS 743B.460 or 750.005,  
24 subject to the following conditions:

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

28 “(b) An insurer or health care service contractor shall, subject to sub-  
29 section (2) of this section, pay benefits toward the covered charges of non-  
30 contracting providers of services for behavioral health treatment. The

1 insured shall, subject to subsection (2) of this section, have the right to use  
2 the services of a noncontracting provider of behavioral health treatment,  
3 whether or not the behavioral health treatment is provided by contracting  
4 or noncontracting providers.

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

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

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

14 “(C) Psychoanalysis or psychotherapy received as part of an educational  
15 or training program, regardless of diagnosis or symptoms that may be pres-  
16 ent;

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

18 “(E) Support groups.

19 “(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may  
20 receive covered outpatient services under the terms of the insured’s policy  
21 while the insured is living temporarily in a sheltered living situation.

22 “[8] (9) The Oregon Health Authority shall establish a process for the  
23 certification of an organization described in subsection (1)(j)(F) of this sec-  
24 tion that:

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

27 “(b) Does not contract with the authority, a subcontractor of the author-  
28 ity or a community mental health program.

29 “[9] (10) The Oregon Health Authority shall adopt by rule standards for  
30 the certification provided under subsection [(8)] (9) of this section to ensure

1 that a certified provider organization offers a distinct and specialized pro-  
2 gram for the treatment of mental or nervous conditions.

3 “[~~(10)~~] **(11)** The Oregon Health Authority may adopt by rule an applica-  
4 tion fee or a certification fee, or both, to be imposed on any provider or-  
5 ganization that applies for certification under subsection [~~(8)~~] **(9)** of this  
6 section. Any fees collected shall be paid into the Oregon Health Authority  
7 Fund established in ORS 413.101 and shall be used only for carrying out the  
8 provisions of subsection [~~(8)~~] **(9)** of this section.

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

17 “[~~(12)~~] **(13)** The Director of the Department of Consumer and Business  
18 Services and the Oregon Health Authority, after notice and hearing, may  
19 adopt reasonable rules not inconsistent with this section that are considered  
20 necessary for the proper administration of this section. The director shall  
21 adopt rules making it a violation of this section for a group health insurer  
22 or issuer of an individual health benefit plan other than a grandfathered  
23 health plan to require providers to bill using a specific billing code or to  
24 restrict the reimbursement paid for particular billing codes other than on the  
25 basis of medical necessity.

26 “[~~(13)~~] **(14)** This section does not:

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

30 “(b) Prohibit the use of value-based payment methods, including global

1 budgets or capitated, bundled, risk-based or other value-based payment  
2 methods.

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

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

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

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