

# A-Engrossed House Bill 2013

Ordered by the House April 15  
Including House Amendments dated April 15

Sponsored by Representative NOSSE; Representative MUNOZ (Presession filed.)

## SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

**Digest: Includes certain places that employ CADCs as providers for mental health treatment. (Flesch Readability Score: 60.7).**

*[Digest: Includes places that employ CADCs as providers for mental health treatment. (Flesch Readability Score: 64.9).]*

Includes outpatient facilities **with a certified substance use disorder program** that employ certified alcohol and drug counselors as providers for the purposes of mental health treatment insurance coverage.

## A BILL FOR AN ACT

1  
2 Relating to mental health treatment providers; amending ORS 743A.168.

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

4 **SECTION 1.** ORS 743A.168, as amended by section 3, chapter 70, Oregon Laws 2024, is amended  
5 to read:

6 743A.168. (1) As used in this section:

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

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

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

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

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

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

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

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

22 (B) Products and services that:

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

**NOTE:** Matter in **boldfaced** type in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted. New sections are in **boldfaced** type.

- 1 (ii) Are clinically appropriate in terms of type, frequency, extent, site and duration; and  
2 (iii) Are not primarily for the economic benefit of an insurer or payer or for the convenience  
3 of a patient, treating physician or other health care provider.
- 4 (f) "Group health insurer" means an insurer, a health maintenance organization or a health care  
5 service contractor.
- 6 (g) "Median maximum allowable reimbursement rate" means the median of all maximum allow-  
7 able reimbursement rates, minus incentive payments, paid for each billing code for each provider  
8 type during a calendar year.
- 9 (h) "Prior authorization" has the meaning given that term in ORS 743B.001.
- 10 (i) "Program" means a particular type or level of service that is organizationally distinct within  
11 a facility.
- 12 (j) "Provider" means:
- 13 (A) A behavioral health professional or medical professional licensed or certified in this state  
14 who has met the credentialing requirement of a group health insurer or an issuer of an individual  
15 health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is oth-  
16 erwise eligible to receive reimbursement for coverage under the policy;
- 17 (B) A health care facility as defined in ORS 433.060;
- 18 (C) A residential facility as defined in ORS 430.010;
- 19 (D) A day or partial hospitalization program;
- 20 (E) An outpatient service as defined in ORS 430.010; [*or*]
- 21 **(F) A licensed outpatient facility with a certified substance use disorder program that**  
22 **employs certified alcohol and drug counselor level providers; or**
- 23 [*F*] (G) A provider organization certified by the Oregon Health Authority under subsection (9)  
24 of this section.
- 25 (k) "Relevant clinical specialties" includes but is not limited to:
- 26 (A) Psychiatry;
- 27 (B) Psychology;
- 28 (C) Clinical sociology;
- 29 (D) Addiction medicine and counseling; and
- 30 (E) Behavioral health treatment.
- 31 (L) "Standards of care and clinical practice guidelines" includes but is not limited to:
- 32 (A) Patient placement criteria;
- 33 (B) Recommendations of agencies of the federal government; and
- 34 (C) Drug labeling approved by the United States Food and Drug Administration.
- 35 (m) "Utilization review" has the meaning given that term in ORS 743B.001.
- 36 (n) "Valid, evidence-based sources" includes but is not limited to:
- 37 (A) Peer-reviewed scientific studies and medical literature;
- 38 (B) Recommendations of nonprofit health care provider professional associations; and
- 39 (C) Specialty societies.
- 40 (2) A group health insurance policy or an individual health benefit plan that is not a grandfa-  
41 thered health plan providing coverage for hospital or medical expenses, other than limited benefit  
42 coverage, shall provide coverage for expenses arising from the diagnosis of behavioral health con-  
43 ditions and medically necessary behavioral health treatment at the same level as, and subject to  
44 limitations no more restrictive than, those imposed on coverage or reimbursement of expenses aris-  
45 ing from treatment for other medical conditions. The following apply to coverage for behavioral

1 health treatment:

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

9 (b) The coverage of behavioral health treatment may not be made subject to treatment limita-  
10 tions, limits on total payments for treatment, limits on duration of treatment or financial require-  
11 ments unless similar limitations or requirements are imposed on coverage of other medical  
12 conditions. The coverage of eligible expenses of behavioral health treatment may be limited to  
13 treatment that is medically necessary as determined in accordance with this section and no more  
14 stringently under the policy 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 necessary in a behavioral  
18 health assessment of the specific needs of a patient or in a patient's care plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (k)(A) Subject to section 2, chapter 70, Oregon Laws 2024, and to the patient or client  
27 confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practi-  
28 tioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical  
29 social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage  
30 and family therapists, a group health insurer or issuer of an individual health benefit plan may  
31 provide for review for level of treatment of admissions and continued stays for treatment in health  
32 facilities, residential facilities, day or partial hospitalization programs and outpatient services by  
33 either staff of a group health insurer or issuer of an individual health benefit plan or personnel  
34 under contract to the group health insurer or issuer of an individual health benefit plan that is not  
35 a grandfathered health plan, or by a utilization review contractor, who shall have the authority to  
36 certify for or deny level of payment.

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

39 (C) Review shall be performed by or under the direction of a physician licensed under ORS  
40 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
41 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
42 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
43 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
44 Medicare review standards of the Centers for Medicare and Medicaid Services.

45 (D) Review may involve prior authorization, concurrent review of the continuation of treatment,

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

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

16 (3) Except as provided in section 2, chapter 70, Oregon Laws 2024, this section does not prohibit  
 17 a group health insurer or issuer of an individual health benefit plan that is not a grandfathered  
 18 health plan from managing the provision of benefits through common methods, including but not  
 19 limited to selectively contracted panels, health plan benefit differential designs, preadmission  
 20 screening, prior authorization of services, utilization review or other mechanisms designed to limit  
 21 eligible expenses to those described in subsection (2)(b) of this section provided such methods comply  
 22 with the requirements of this section.

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

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

30 (A) The current generally accepted standards of care.

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

33 (C) For medical necessity, utilization or other clinical review conducted for the diagnosis, pre-  
 34 vention or treatment of behavioral health conditions that does not involve level of care placement  
 35 decisions, other criteria and guidelines may be utilized if such criteria and guidelines are based on  
 36 the current generally accepted standards of care including valid, evidence-based sources and current  
 37 treatment criteria or practice guidelines developed by the nonprofit professional association for the  
 38 relevant clinical specialty. Such other criteria and guidelines must be made publicly available and  
 39 made available to insureds upon request to the extent permitted by copyright laws.

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

42 (A) Are outside the scope of criteria and guidelines described in paragraph (a)(B) of this sub-  
 43 section, if the guidelines were developed in accordance with the current generally accepted stan-  
 44 dards of care; or

45 (B) Are based on advancements in technology of types of care that are not addressed in the most

1 recent versions of sources specified in paragraph (a)(B) of this subsection, if the guidelines were  
2 developed in accordance with current generally accepted standards of care.

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

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

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

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

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

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

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

31 (8)(a) This section does not require coverage for:

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

34 (B) A long-term residential mental health program that lasts longer than 45 days unless clin-  
35 ically indicated under criteria and guidelines described in subsection (5) of this section;

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

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

39 (E) Support groups.

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

43 (9) The Oregon Health Authority shall establish a process for the certification of an organiza-  
44 tion described in subsection [(1)(j)(F)] (1)(j)(G) of this section that:

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

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

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

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

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

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

24 (14) This section does not:

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

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

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

32