

LC 502
2023 Regular Session
44300-023
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D R A F T

SUMMARY

Requires health insurance coverage for specified types of behavioral health care.

A BILL FOR AN ACT

Relating to behavioral health care; creating new provisions; and amending ORS 743A.168.

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

SECTION 1. ORS 743A.168, as amended by section 8, chapter 629, Oregon Laws 2021, is amended to read:

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

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

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

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

(d) “Crisis services” means the services described in ORS 414.766 (1)(a).

[(d)] (e) “Facility” means a corporate or governmental entity or other

provider of services for the treatment of behavioral health conditions.

[(e)] (f) “Generally accepted standards of care” means:

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

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

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

(B) Products and services that:

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

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

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

(g) “Group health insurance policy” means a policy, certificate or health care service contract for coverage of health care and services offered to a group by a group health insurer.

[(f)] (h) “Group health insurer” means an insurer, a health maintenance organization or a health care service contractor.

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

[(h)] (j) “Prior authorization” has the meaning given that term in ORS 743B.001.

[(i)] (k) “Program” means a particular type or level of service that is organizationally distinct within a facility.

[(j)] (L) “Provider” means:

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

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 (9) of this section.

10 [(k)] (m) “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)] (n) “Standards of care and clinical practice guidelines” includes but
17 is 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 Admin-
21 istration.

22 [(m)] (o) “Utilization review” has the meaning given that term in ORS
23 743B.001.

24 [(n)] (p) “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
31 medical expenses, other than limited benefit coverage, shall provide coverage

for expenses arising from the diagnosis of behavioral health conditions and medically necessary behavioral health treatment at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for behavioral health treatment:

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

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

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

(A) A behavioral health assessment;

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

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

(ii) For care following a behavioral health crisis, to transition the patient

1 to a lower level of care;

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

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

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

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

9 (G) Treatment for an appropriate duration based on the insured's partic-
10 ular needs;

11 (H) Treatment appropriate to the unique needs of children and adoles-
12 cents;

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

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

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

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

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

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

31 (B) The provider is accredited for the particular level of care for which

1 reimbursement is being requested by the Joint Commission or the Commis-
2 sion on Accreditation of Rehabilitation Facilities;

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

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

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

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

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

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

29 (k)(A) Subject to the patient or client confidentiality provisions of ORS
30 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS
31 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed

1 clinical social workers and ORS 40.262 relating to licensed professional
2 counselors and licensed marriage and family therapists, a group health
3 insurer or issuer of an individual health benefit plan may provide for review
4 for level of treatment of admissions and continued stays for treatment in
5 health facilities, residential facilities, day or partial hospitalization programs
6 and outpatient services by either staff of a group health insurer or issuer
7 of an individual health benefit plan or personnel under contract to the group
8 health insurer or issuer of an individual health benefit plan that is not a
9 grandfathered health plan, or by a utilization review contractor, who shall
10 have the authority to certify for or deny level of payment.

11 (B) Review shall be made according to criteria made available to provid-
12 ers in advance upon request.

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

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

these procedures to the same extent as contracting providers to be eligible for reimbursement.

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

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

(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either directly or by reference, in accordance with this section.

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

(A) The current generally accepted standards of care.

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

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

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

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

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

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

(6) To ensure the proper use of any criteria and guidelines described in subsection (5) of this section, a group health insurer or an issuer of an in-

dividual health benefit plan shall provide, at no cost:

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

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

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

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

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

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

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

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

(C) Psychoanalysis or psychotherapy received as part of an educational

or training program, regardless of diagnosis or symptoms that may be present;

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

(E) Support groups.

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

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

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

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

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

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

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

contract.

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

(14) This section does not:

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

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

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

(15) A group health insurance policy and an individual health benefit plan that reimburses the cost of care or treatment for a behavioral health condition may not exclude coverage of:

(a) Crisis services offered at a walk-in facility.

(b) Emergency evaluation and treatment, outpatient care and timely and appropriate inpatient care provided by a facility or by direct arrangement by the facility with other public or private agencies that are licensed or certified by the Oregon Health Authority to provide such care.

(c) Outpatient crisis services provided by an agency licensed or certified by the authority to provide crisis services.

(d) Medically managed or medically monitored withdrawal man-

1 **agement services provided by an agency licensed or certified to provide**
2 **such services.**

3 (e) Crisis services provided by a mobile crisis intervention team as
4 defined in ORS 430.626.

5 **(16) This section is exempt from ORS 743A.001.**

6 **SECTION 2. The amendments to ORS 743A.168 by section 1 of this**
7 **2023 Act apply to policies, certificates or contracts issued, renewed or**
8 **extended on or after the effective date of this 2023 Act.**

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