HB 3046 – Mental health parity
Edits to current rule – discussion draft

836-053-0012

Essential Health Benefits for Plan Years Beginning on and after January 1, 2017

(1) This rule applies to plan years beginning on and after January 1, 2017.

(2) As used in the Insurance Code and OAR chapter 836:

(a) “Applied behavior analysis” has that meaning given in ORS 676.802.

~~Section 2, chapter 771, Oregon Laws 2013 as amended by Section 9, chapter 674, Oregon Laws 2015.~~

(b) “Base benchmark health benefit plan” means the PacificSource Health Plans Preferred CoDeduct Value 3000 35 70 small group health benefit plan, including prescription drug benefits, as provided in Exhibit 1 to this rule;

(c) “Behavioral health condition” has the meaning given in OAR 836-053-1404.

(d~~c~~) “Essential health benefits” or “EHB” means the following coverage provided in compliance with 45 CFR 156:

(A) The base-benchmark health benefit plan with the exclusions and modifications of provisions of that plan as set forth in section (3) to (7) of this rule.

(B) Pediatric dental benefits;

(C) Pediatric vision benefits; and

(D) Habilitative services and devices.

(e~~d~~) “Habilitative services and devices” means services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services and devices must include physical and occupational therapy, speech-language pathology and other services and devices for people with disabilities in a variety of inpatient or outpatient settings.

~~“Mental or nervous condition” has that meaning given in OAR 836-053-1404.~~

(f) “Pediatric dental benefits” means the benefits described in the Dental Plan of the Oregon Health Plan Children’s’ Health Insurance Plan as provided in Exhibit 2 of this rule. Pediatric dental benefits are payable to persons under 19 years of age.

(g) “Pediatric vision benefits” means the benefits described in the vision provisions of the Federal Employee Dental and Vision Insurance Plan Blue Vision High Option as provided in Exhibit 3 of this rule. Pediatric vision benefits are payable to persons under 19 years of age.

(h) “Treatment of a ~~mental~~ behavioral health condition” includes medical treatments and prescription drugs used to treat a ~~mental or nervous~~behavioral health condition.

(3) The following exclusions and modifications are required supplementation to the base-benchmark health benefit plan:

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(a) The following treatment limitations and exclusions of coverage currently included in the base-benchmark health benefit plan are excluded:

(A) The 24-month waiting period for transplant benefits;

(B) Visit limits for inpatient and outpatient ~~mental~~ behavioral health services, including but not limited to habilitative and rehabilitative benefits;

(C) Age limits on treatments that would otherwise be appropriate for individuals outside of the limited age, including but not limited to hearing aids, speech, physical and occupational therapy used in the treatment of ~~mental or nervous~~behavioral health conditions as defined in OAR 836-053-1404;

(D) Exclusions for the treatment of erectile dysfunction or sexual dysfunction as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)~~. or the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition" (DSM-IV)~~;

(E) Exclusions for medically necessary surgeries and procedures related to sex transformations and gender identity disorder or gender dysphoria;

(F) Any blanket exclusion for a diagnosis made using the diagnostic criteria of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).~~the DSM-5 or the DSM-IV~~;

(G) Exclusions for court-order screening interviews or drug or alcohol treatment programs;

(H) Any limitations or waiting periods for pre-existing conditions;

(I) Time limits for treatment of jaw or teeth or orthognathic surgery; and

(b) Dollar limits for coverage of durable medical equipment must comply with the following:

(A) Annual dollar limits must be converted to a non-dollar actuarial equivalent.

(B) Lifetime dollar limits must be converted to a non-dollar actuarial equivalent.

(c) The following provisions of the base-benchmark plan must be modified:

(A) Any waiting periods must be consistent with limitations imposed by state or federal law;

(B) Wigs following chemotherapy or radiation therapy must be covered up to the actuarial equivalent of $150 per calendar year;

(C) The limitation on cosmetic or reconstructive surgery to one attempt within 18 months of injury or defect must be modified to remove these limitations in cases of medical necessity in accordance with 45 CFR 156.125(a) and to avoid discrimination based on health factors under 45 CFR 146.121;

(D) Contraceptive coverage must comply with Centers for Medicare and Medicaid Services guidance and requirements related to contraception issued jointly by the United States Departments of Labor, Health and Human Services, and Treasury on May 11, 2015;

(E) Provisions related to telemedical health services must reflect changes made to ORS 743A.058 by chapter ~~340~~117, Oregon Laws 20~~15~~21 (Enrolled ~~Senate~~ House Bill ~~144~~2508); and

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(F) Housing and travel expenses for transplant services are not considered essential health benefits;

(4) An insurer that issues a health benefit plan offering essential health benefits may not include as an essential health benefit:

(a) Routine non-pediatric dental services;

(b) Routine non-pediatric eye exam services;

(c) Long-term care or custodial nursing home care benefits; or

(d) Non-medically necessary orthodontia services.

(5) If both a state law and federal law require coverage of the same or similar service, the insurer must assure that all elements of both laws are met and provide the coverage in the manner most beneficial to the consumer.

(6) In the administration of essential health benefits and the EHB base benchmark health benefit plan, an insurer may not discriminate against a provider acting within the scope of the provider's license.

(7) In the administration of essential health benefits and the EHB base benchmark health benefit plan an insurer may not exclude services provided by a naturopathic physician if the services are otherwise covered under the plan and the naturopathic physician is acting within the scope of the provider's license.

(8) In the administration of essential health benefits and the EHB base benchmark health benefit plan an insurer may not exclude services provided by a doctor of chiropractic medicine if the services are otherwise covered under the plan and the doctor of chiropractic medicine is acting within the scope of the provider's license.

Statutory/Other Authority: ORS 731.097

Statutes/Other Implemented: ORS 731.097 & OL 2021, chap. 117

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836-053-1403

Definitions of Coordinated Care and Case Management for Behavioral Health Care Services

~~As used in ORS 743A.168:~~

(1) The definitions set forth in ~~section 5 of Section 4, Chapter 273, Oregon Laws 2017~~ORS 743A.168 apply to the use of those terms in these rules.

(2) “Caring contacts” mean brief communications with a patient that start during care transition such as discharge or release from treatment, or when a patient misses an appointment or drops out of treatment, and continues as long as a qualified mental health professional deems necessary.

(3) “Case management” means the management of services that are provided to assist an individual in accessing medical and behavioral health care, social and educational services, public assistance and medical assistance and other needed community services identified in the individual’s patient-centered care plan.

(4) “Coordination of care” means the process of coordinating patient care activities as well as the facilitation of ongoing communication and collaboration with lay caregivers by community resource providers, health care providers, and agencies to meet the multiple needs of a patient by:

(a) Organizing and participating in team meetings; and

(b) Ensuring continuity of care during each transition of care.

(5) “Crisis stabilization plan” means an individually tailored plan provided to a patient and the patient’s lay caregiver that:

(a) Is based on the patient’s behavioral health assessment and physical health assessment; and

(b) Describes the patient’s specific short-term rehabilitation objectives and proposed crisis interventions.

(6) “Lay caregiver” means:

(a) For a patient who is younger than 14 years of age, a parent or legal guardian of the patient.

(b) For a patient who is at least 14 years of age or older, an individual designated by the patient or a parent or legal guardian of the patient to the extent permitted under ORS 109.640 and 109.675.

(c) For a patient who is at least 14 years of age or older, and who has not designated a caregiver, an individual to whom a health care provider may disclose protected health information without a signed authorization under ORS 192.567.

(7) “Lethal means counseling” means counseling strategies designed to reduce the access by a patient who is at risk for suicide to lethal means, including but not limited to firearms.

(8) “Medically appropriate treatment” means the services and supports necessary to diagnose, stabilize, care for and treat a behavioral health condition.

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(9) “Patient centered care” means care provided in a manner that:

(a) Is respectful of and responsive to a patient’s preferences, needs and values; and

(b) Ensures that all clinical decisions are guided by the patient’s values.

(10) “Peer delivered services” means an array of support services provided by agencies or community-based organizations to patients or family members of patients:

(a) Using peer support specialists; and

(b) That are designed to support the needs of patients and their families.

(11) “Peer support specialist” means a Peer Wellness Specialist or a Peer Support Specialist, including Family Support Specialist and Youth Support Specialist, as defined in ORS 414.025 and 414.665 and certified under OAR 410-180-0310 to 410-180-0312.

(12) “Qualified mental health professional” means an individual meeting the minimum qualification criteria adopted by the Oregon Health Authority by rule for a qualified mental health professional.

(13) “Safety plan” means a written plan developed by a patient in collaboration with the patient’s lay caregiver, if any, as facilitated by a health care provider that identifies strategies for the patient or lay caregiver to use when the patient’s risk for suicide is elevated or following a suicide attempt.

(14) “Transition of care” means the process of transferring a patient from one provider or care setting to another provider or care setting.

(15) Coordination of Care and Case Management processes shall ensure coordination and management of services when indicated by a behavioral health assessment conducted by a behavioral health clinician, including, but not limited to:

(a) A best practices risk assessment and, if indicated, a safety plan and lethal means counseling;

(b) A determination of the patient’s clinical needs and recommendations, if within the scope of the provider’s practice, for medically appropriate treatment including but not limited to one or more of the following:

(A) Adjusting or prescribing medication;

(B) Therapeutic services;

(C) Other medically appropriate treatment; or

(D) Peer delivered services.

(c) Caring contacts.

(d) Recommendations as required or permitted under ORS 192.567, 441.054~~441.196~~ and 441.051~~441.198~~ to the patient, lay caregiver and health care provider.

(e) Informing the patient, lay caregiver and health care provider of the practitioners who can provide the recommended services and how to access the practitioners and other community-based resources.

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(f) Explaining to the patient and the lay caregiver crisis stabilization planning and patient centered care and establishing a goal of convening a care team.

(g) Identifying a person to provide coordination of care who:

(A) Is part of a ~~patient centered~~ behavioral health home, as defined in ORS 414.025, a patient centered primary care home, as defined in ORS 414.025, or a patient centered medical home recognized by the National Committee for Quality Assurance;

(B) Is appropriately licensed or certified;

(C) Will communicate directly with the patient and the lay caregiver; and

(D) When possible or requested, will meet personally with the patient and the lay caregiver.

(h) Creating with the patient and the lay caregiver a plan for the transition of care and sharing the plan with the patient's health care providers and care team.

Statutory/Other Authority: ORS 731.244 ~~& OL 2017, Ch. 273 §5~~ 743A.168

Statutes/Other Implemented: ~~OL 2017, Ch. 273 §5~~ ORS 743A.168

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836-053-1404

Definitions; Noncontracting Providers; Co-Morbidity Disorders

(1) As used in ORS 743A.168 and OAR Chapter 836:

(a) “Behavioral health condition” ~~"Mental or nervous conditions"~~ means any mental or substance use disorder covered by diagnostic categories listed in the ~~in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV) or,~~ Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, Text Revision" (DSM-5-TR), the International Classification of Diseases, 10th Revision (ICD-10), or the International Classification of Diseases, 11th Revision (ICD-11).

~~(b) "Chemical dependency" means an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems.~~

~~(c) "Chemical dependency" does not mean an addiction to, or dependency on:~~

~~(A) Tobacco;~~

~~(B) Tobacco products; or~~

~~(C) Foods.~~

(b) “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.

(c)“Valid, evidence-based sources” includes but is not limited to:

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

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

(C) Specialty societies.

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(2) A non-contracting provider must cooperate with a ~~group~~ health insurer's requirements for review of treatment in ORS 743A.168(~~10~~2) and (~~11~~3) to the same extent as a contracting provider in order to be eligible for reimbursement.

(3) The exception of a disorder in the definition of ~~"mental or nervous conditions" or "chemical dependency"~~"behavioral health condition" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

Statutory/Other Authority: ORS 731.244 & 743A.168

Statutes/Other Implemented: ORS 743A.168

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HB 3046 – Mental health parity
Edits to current rule – discussion draft

836-053-1405

General Requirements for Coverage of ~~Mental or Nervous Conditions and Chemical Dependency~~Behavioral Health Conditions

(1) A group health insurance policy or an individual health benefit plan issued or renewed in this state shall provide coverage or reimbursement for medically necessary treatment, including but not limited to prescription drugs, of ~~mental or nervous conditions~~behavioral health conditions ~~and chemical dependency, including~~ at the same level as, and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for ~~other~~ medical or surgical conditions.

(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 behavioral health treatment may not be greater than those under the policy for medical or surgical 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 medical or surgical conditions.

(c) The parity requirements in subsections (1)(a) and (b) must comply with the “predominant” and “substantially all” tests in the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 45 CFR 147.160.

(d) If annual or lifetime limits apply for treatment of behavioral health conditions the limits must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160.

(e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat behavioral health conditions must be by the same process as drug selection for formulary status applied for drugs intended to treat medical or surgical conditions, regardless of whether such drugs are intended to treat behavioral health conditions or medical or surgical conditions.

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

(g) The coverage of behavioral health treatment must include clinically indicated outpatient coverage including follow-up in-home services or other outpatient services. The policy may limit coverage only if clinically indicated under 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. Utilization and clinical review policies and procedures must meet the requirements of OAR 836-053-1405(9), (10), (11), and (12), as well as comply with the entire definition of “generally accepted standards of care” in OAR 836-053-1404.

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(2) A group health insurer or an issuer of an individual health benefit plan issued of renewed in this state must use the same methodology to set reimbursement rates paid to behavioral health treatment providers that the group health insurer or issuer of an individual health benefit plan uses to set reimbursement rates for medical and surgical treatment providers.

(3) A group health insurer -or an issuer of an individual health benefit plan issued or renewed in this state must update the methodology and rates for reimbursing behavioral health treatment providers in a manner equivalent to the manner in which the group health insurer or issuer of an individual health benefit plan updates the methodology and rates for reimbursing medical and surgical treatment providers, unless otherwise required by federal law.

~~(2) For the purposes of ORS 743A.168, the following standards apply in determining whether coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions~~behavioral health ~~provided 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:~~

~~(a) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for mental or nervous~~behavioral health ~~conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for medical and surgical services otherwise provided under the health insurance policy.~~

~~(b) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services for mental or nervous~~behavioral health ~~conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing, including, but not limited to, deductibles for wellness and preventive services otherwise provided under the health insurance policy.~~

~~(c) If annual or lifetime limits apply for treatment of mental or nervous conditions~~behavioral health conditions ~~and chemical dependency, including alcoholism the limits must comply with the "predominately equal" to and "substantially all" tests the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. 1185a and implementing regulations at 45 CFR 146.136 and 147.160.~~

~~(d) The co-payment, coinsurance, reimbursement, or other cost sharing, including, but not limited to, deductibles expenses for prescription drugs intended to treat mental or nervous~~behavioral health ~~conditions and chemical dependency, including alcoholism, may be no more than the co-payment or coinsurance, or other cost sharing expenses for prescription drugs prescribed for other medical services provided under the health insurance policy.~~

~~(e) Classification of prescription drugs into open, closed, or tiered drug benefit formularies, for drugs intended to treat mental or nervous~~behavioral health ~~conditions and chemical dependency, including alcoholism, must be by the same process as drug selection for formulary status applied for drugs~~

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~~intended to treat other medical conditions, regardless of whether such drugs are intended to treat mental or nervous~~behavioral health ~~conditions, chemical dependency, including alcoholism, or other medical conditions.~~“”

(~~5~~4) A group health insurance policy or an individual health benefit plan issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical and behavioral ~~, mental or nervous conditions~~health conditions. ~~, and chemical dependency, including alcoholism.~~

(~~6~~5) A ~~group health insurer that issues or renews a~~ group health insurance policy or an individual health benefit plan in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical~~, mental or nervous conditions, and chemical dependency, including alcoholism~~ and behavioral health conditions.~~.~~

(~~7~~6) Subject to subsection (5) of ORS 743A.168 and OAR 836-053-1405(10), (11), (12), and (13), ~~C~~coverage for expenses arising from treatment for ~~mental or nervous~~behavioral health conditions ~~and chemical dependency, including alcoholism,~~ may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses arising from ~~other~~ a medical or surgical condition. Common methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.

(7~~8~~) Any medical necessity, utilization or other clinical review~~,~~ not related to level of care placement decisions, must be based on:~~;~~

(a) the current generally accepted standards of care; ~~and~~or

(b) treatment criteria guidelines developed by the nonprofit professional association for the relevant clinical specialty~~that are~~ .

(8~~9~~) For medical necessity, utilization or other clinical review~~,~~ not related to level of care placement decisions, other criteria may be utilized as long as it is based on the current generally accepted standards of care including valid, evidence-based sources.

(9~~10~~) Any medical necessity, utilization or other clinical review relating to level of care placement decisions,~~ continued stay or discharge~~ must be based ~~solely~~ on~~ the following~~:~~;~~

(a) The current generally accepted standards of care; and

(b) The levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty~~that are~~ .

(c) In instances where there are no guidelines or criteria from the nonprofit professional association for the relevant clinical specialty, other criteria may be utilized if the criteria ~~is~~are based on the generally accepted standards of care, and may include advancements in technology of types of care. ~~Other criteria utilized are subject to review and approval by the Department or its designee.~~ Other criteria utilized must be made available to the Department upon request.

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(d) For purposes of ~~utilization review determinations concerning~~ medical necessity, utilization or other clinical review relating to level of care placement decisions the following guidelines or criteria ~~shall~~ will be considered compliant:

(A) For a primary substance use disorder diagnosis in adolescents and adults, the ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition (2013), by the American Society of Addiction Medicine (https://www.asam.org/asam-criteria)

(B) For a primary mental health diagnosis in adults nineteen (19) years of age and older, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), Adult Version 20, by the American Association for Community Psychiatry (https://sites.google.com/view/aacp123/resources/locus).

(C) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/aacap/Member_Resources/Practice_Information/CALOCUS_CASII.aspx).

(D) For a primary mental health diagnosis in children five (5) years of age and younger, Early Child Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry (https://www.aacap.org/aacap/Member_Resources/Practice_Information/ECSII.aspx).

(10~~1~~) All level of care placement decisions must be authorized at the level of care consistent with the insured's score or assessment using generally accepted standards of care and the relevant level of care placement criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty. If the level of care indicated by the criteria and guidelines is not available, the insurer shall authorize the next highest level of care based on the generally accepted standards 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 including information on the generally accepted standards of care or other criteria used to make the level of care decision.

(11~~2~~) A group health insurer or an individual health benefit plan shall provide, at no cost:

(a) A one-time formal education program for the insurer and insurer staff who conduct medical necessity, utilization and other clinical reviews on the proper use of such reviews. The training must be presented by nonprofit clinical specialty associations or other entities authorized by the department.

(b) Medical necessity, utilization or other clinical review criteria used by the insurer, and any education or training materials regarding medical necessity, utilization or other clinical review criteria to stakeholders, including participating providers and enrollees.

(c) Nothing in this section prohibits a group health insurer or an issuer of an individual health benefit plan from requiring providers to bill in accordance with generally accepted coding standards including the National Correct Coding Initiative

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(12~~3~~) A group health insurer or ~~issuer of~~ an individual health benefit plan ~~other than a grandfathered health plan~~ may not 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.

(1~~4~~3) This rule 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, to the extent permitted under state and federal law.

(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.

(145~~6~~) Nothing in this rule prevents a group health insurance policy or an individual health benefit plan from providing coverage for conditions or disorders excepted under the definition of "~~mental or nervous~~behavioral health condition" in OAR 836-053-1404.

(15~~6~~) The Director shall review OAR 836-053-1404 to 836-053-1408 and any other materials every two years to determine whether the requirements set forth in the rules are uniformly applied to all medical~~,~~ ~~mental or nervous~~ and behavioral health conditions~~, and chemical dependency, including alcoholism.~~.

Statutory/Other Authority: ORS 731.244, 743A.168 & OR Laws 2021, chap. 629

Statutes/Other Implemented: ORS 743A.168 & OR Laws 2021, chap. 629

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836-053-1407

Prohibited Exclusions

(1) An insurer may not deny benefits for a medically necessary treatment or service for a ~~mental or nervous~~behavioral health condition based solely upon:

(a) The enrollee's interruption of or failure to complete a prior course of treatment;

(b)The insurer's categorical exclusion of such treatment or service when applied to a class of ~~mental or nervous~~behavioral health conditions; or

(c) The fact that a court ordered the enrollee to receive or obtain the treatment or service for a ~~mental or nervous~~behavioral health condition, unless otherwise allowed by law.

(2) Nothing in this section:

(a) Requires coverage of a treatment or service that is or may be specifically excluded from coverage under state law.

(b) Prohibits an insurer from including a provision in a contract related to the insurer's general responsibility to pay for any service under the plan such as an exclusion for third party liability.

(c) Requires an insurer to pay for services provided to an enrollee by a school or halfway house or received as part of an educational or training program. However, an insurer may be required to provide coverage of treatment or services related to the enrollee's education that are provided by a provider and that are included in a medically necessary treatment plan.

Statutory/Other Authority: ORS 731.244 & 743A.168

Statutes/Other Implemented: ORS 743A.168

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836-053-1408

Required Disclosures

(1) Insurers must provide an enrollee or an enrollee's authorized representative reasonable access to and copies of all documents, records, and other information relevant to an enrollee's claim or request for coverage.

(2) Insurers must provide the criteria, guidelines, processes, standards and other factors used to ~~make~~ conduct medical necessity, utilization or other clinical ~~determinations of benefits for~~reviews for ~~mental or nervous~~behavioral health conditions. This information must be made available free of charge by the insurer to any current or potential enrollee, beneficiary, or contracting provider upon request, within a reasonable time and in a manner that provides reasonable access to the requestor.

(3) Compliance with these disclosure requirements is not determinative of compliance with any other provisions of applicable federal or state law.

Statutory/Other Authority: ORS 731.244 & 743A.168

Statutes/Other Implemented: ORS 743A.168

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836-053-0320

Annual Report Requirements for Network Adequacy

(1) An insurer offering individual or small group health benefits plans must submit its annual report for each network required under **ORS 743B.505** no later than March 31 of each year.

(2) Beginning March 31, 2020, the annual report shall include at least the following information for networks associated with health benefit plans currently in force and networks associated with health benefit plans being marketed at the time the report is submitted:

(a) Identification of the insurer's network, including plans to which the network applies, how the use of telemedicine or telehealth or other technology may be used to meet network access standards;

(b) The insurer's procedures for making and authorizing referrals within and outside its network, if applicable;

(c) The insurer's procedures for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans;

(d) The factors used by the insurer to build its provider network, including a description of the network and the criteria used to select or tier providers;

(e) The insurer's efforts to address the needs of enrollees, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, gay, lesbian, bisexual, transgender, and any other minority gender identity or sexual orientation, physical or mental disabilities, and serious, chronic~~, or~~ complex medical or behavioral health conditions. This information must include the insurer's efforts, when appropriate, to include various types of essential community providers in its network;

(f) The insurer's process for ensuring networks for plans sold outside of the marketplace provide enrollees who reside in low-income zip code areas or who reside in health professional shortage areas with adequate access to care without delay;

(g) The insurer's methods for assessing the health care needs of enrollees and their satisfaction with services;

(h) The insurer's method of informing enrollees of the plan's covered services and features, including but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

(D) A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and

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(E) Its procedures for covering and approving emergency, urgent and specialty care, if applicable.

(i) The insurer's system for ensuring the coordination and continuity of care:

(A) For enrollees referred to specialty physicians; and

(B) For enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.

(j) The insurer's process for enabling enrollees to change primary care professionals, if applicable;

(k) The insurer's proposed plan for providing continuity of care in the event of contract termination between the insurer and any of its participating providers, or in the event of the insurer's insolvency or other inability to continue operations. The description shall explain how enrollees will be notified of the contract termination, or the insurer's insolvency or other cessation of operations, and transitioned to other providers in a timely manner; and

(l) The insurer's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals.

Statutory/Other Authority: ORS 731.244 & ORS 743B.505

Statutes/Other Implemented: ORS 743B.505

History:

ID 6-2019, amend filed 06/17/2019, effective 07/01/2019

ID 10-2016, f. & cert. ef. 9-14-16

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