

Enrolled Senate Bill 1

Sponsored by Senators COURTNEY, BROWN; Senators CARTER, GORDLY, MORRISETTE, WALKER, WESTLUND, Representatives BOONE, DINGFELDER, THATCHER

CHAPTER

AN ACT

Relating to limitations on health insurance coverage; creating new provisions; amending ORS 743.556; repealing ORS 430.065; and prescribing an effective date.

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

SECTION 1. ORS 743.556 is amended to read:

743.556. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions **at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.** The following *[conditions apply to the requirement for such]* **apply to coverage for chemical dependency and for mental or nervous conditions:**

(1) **As used in this section:**

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

(b) **“Facility” means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.**

(c) **“Group health insurer” means an insurer, a health maintenance organization or a health care service contractor.**

(d) **“Program” means a particular type or level of service that is organizationally distinct within a facility.**

(e) **“Provider” means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:**

- (A) **A health care facility;**
- (B) **A residential program or facility;**
- (C) **A day or partial hospitalization program;**
- (D) **An outpatient service; or**
- (E) **An individual behavioral health or medical professional authorized for reimbursement under Oregon law.**

[(1)] (2) 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 deductibles and

coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities *[shall be no]* **may not be** greater than those under the policy for expenses of hospitalization in the treatment of *[illness]* **other medical conditions**. Deductibles and coinsurance for outpatient treatment *[shall be no]* **may not be** greater than those under the policy for expenses of outpatient treatment of *[illness]* **other medical conditions**.

(3) The coverage 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 may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or half-way house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(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) A screening interview or treatment program under ORS 813.021.

(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.

[(2)] **(5)** *[Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall]* **A provider** *[be considered]* **is** eligible for reimbursement **under this section** if *[it is provided by]*:

(a) *[Programs or providers described in ORS 430.010 or]* **The provider is** approved by the Department of Human Services *[under subsection (3) of this section.];*

(b) *[Programs]* **The provider is** accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities*].;*

[(c)] *[Inpatient programs provided by health care facilities as defined in ORS 442.015. Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement.]*

[(d)] **(c)** *[Residential programs or facilities described in subsection (3) of this section if]* The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week*].;* **or**

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

[(e)] *[Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430.010 (4)(a) and which meet the standards established under subsection (3) of this section.]*

[(3)] *[Subject to ORS 430.065, the Department of Human Services shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the department or any county mental health program. The department shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that are not related to the department or any county mental health program.]*

[(4)] *[A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Department of Human Services shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the department and any county mental health program.]*

[(5) As used in this section:]

[(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.]

[(b) "Child or adolescent" means a person who is 17 years of age or younger.]

[(c) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.]

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

[(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than \$13,125 for adults and \$15,625 for children or adolescents. For persons requesting payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than \$8,125 for adults and \$13,125 for children and adolescents.]

[(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition.]

[(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.]

*[(9) (6) Payments [shall] **may** not be made under this section [for educational programs to which drivers are referred by the judicial system, nor] for [volunteer mutual] support groups.*

[(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder:]

[(a) For chemical dependency to an amount less than \$5,625 for adults and \$5,000 for children or adolescents; and]

[(b) For mental or nervous conditions to an amount less than \$5,000 for adults and \$7,500 for children or adolescents.]

[(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs:]

[(a) For chemical dependency to an amount less than \$4,375 for adults and \$3,750 for children or adolescents; and]

[(b) For mental or nervous conditions to an amount less than \$1,250 for adults and \$3,125 for children or adolescents.]

[(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment:]

[(a) For chemical dependency to an amount less than \$10,625 for children or adolescents; and]

[(b) For mental or nervous conditions to an amount less than \$10,625 for adults and \$13,125 for children or adolescents.]

[(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for out-patient services, the policy shall not limit payments:]

[(a) For chemical dependency to an amount less than \$1,875 for adults and \$2,500 for children or adolescents; and]

[(b) For mental or nervous conditions to an amount less than \$2,500.]

[(14)] (7) If [so] specified in the policy, outpatient coverage may include follow-up in-home service [associated with any health care facility, residential, day or partial hospitalization] or outpatient services. The policy may limit coverage for in-home service to persons who [have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not terminate that initial treatment against advice] **are homebound under the care of a physician.** [The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.]

(8) Nothing in this section prohibits a group health insurer 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 (3) of this section.

[(15)] (9) [Under ORS 430.021 and 430.315,] The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by [assuring] **ensuring** that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

[(16)] A group health insurance policy may provide, with respect to treatment for chemical dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:]

[(a)] Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities.]

[(b)] (10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to licensed clinical social workers, **a group health insurer may provide for** review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either **group health** insurer staff or personnel under contract to the **group health** insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment[:].

[(A)] (b) [This] Review shall be made according to criteria made available to providers in advance upon request.

[(B)] To facilitate implementation of utilization review programs by insurers, the Director of Human Services shall draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The director shall revise these criteria at least every two years. In developing and revising these criteria, the director shall organize a technical advisory panel including representatives of the Department of Consumer and Business Services, the Department of Human Services, the insurance industry, the business community and providers of each level of care. The director shall place substantial weight on the advice of this panel.]

[(C)] (c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon,[:]; a psychologist licensed by the State Board of Psychologist Examiners[:]; a nurse practitioner registered by the Oregon State Board of Nursing[:]; or a clinical social worker licensed by the State Board of Clinical Social Workers, **in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.** [with physician

consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services.]

*[(D)] (d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, **group health** insurers shall permit [treatment] providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. **Group health** insurers shall provide a timely response to such inquiries. [Approval of a particular admission does not represent a guarantee of future payment.] **Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.***

[(E) An appeals process shall be provided.]

[(F) An insurer may choose to review all providers on a sampling or audit basis only; or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer.]

[(17) For purposes of subsection (16)(b) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.]

[(18) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:]

[(a) The current living situation;]

[(b) An alternative, nontreatment living situation;]

[(c) An alternative residential program or facility; or]

[(d) A day or partial hospitalization program.]

[(19) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services:]

[(a) Are not presently appropriate and available;]

[(b) Cannot be readily and timely made available; and]

[(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.]

[(20) For purposes of subsection (16)(b) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis.]

[(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of \$300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level.]

[(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.]

[(23) Health maintenance organizations, as defined in ORS 750.005, shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees:]

[(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other insurance policies which are subject to the provisions of this chapter for that type and level of service.]

[(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section.]

*[(c) (11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers [associated] **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.***

[(d) The Department of Human Services shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection.]

*[(24) (12) Nothing in this section [shall prevent] **prevents [an] a group health** insurer [or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section,] from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:*

[(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available.]

[(b) An insurer or health care service contractor, other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section.]

*[(c) (a) [An] **A group health** insurer [or health care service contractor] is not required to contract with all eligible providers[, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section].*

*[(d) (b) [Insurers and health care service contractors other than health maintenance organizations] **An insurer or health care services contractor** shall, **subject to subsections (2) and (3) of this section**, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions [at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract]. The insured shall, **subject to subsections (2) and (3) of this section**, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions[. *Policies described in this subsection shall be subject to the provisions of subsection (1) of this section*], whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.*

[(e) The department shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.]

*[(25) (13) 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 [assure] **ensure** continuing access to levels of care most appropriate for the insured's condition and progress.*

[26] (14) The [director] **Director of the Department of Consumer and Business Services**, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions.

SECTION 2. ORS 430.065 is repealed.

SECTION 3. The amendments to ORS 743.556 by section 1 of this 2005 Act apply to group health insurance policies issued or renewed on or after January 1, 2007.

SECTION 4. This 2005 Act takes effect on January 1, 2007.

Passed by Senate March 21, 2005

.....
Secretary of Senate

.....
President of Senate

Passed by House July 30, 2005

.....
Speaker of House

Received by Governor:

.....M.,....., 2005

Approved:

.....M.,....., 2005

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2005

.....
Secretary of State