Inpatient and Outpatient Mental Health

Policy Number: BIP101.L
Effective Date: August 1, 2024

➲ Instructions for Use

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H. R. 1424 Emergency Economic Stabilization Act of 2008, Section 512, Mental Health Parity

https://www.govinfo.gov/content/pkg/PLAW-110publ343/html/PLAW-110publ343.htm

Amendments to ERISA. Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended- (1) in subsection (a), by adding at the end the following:

(3) Financial Requirements and Treatment Limitations

- In General-In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:
  - The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
  - The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Oklahoma

Department of Insurance Title 36, Section 6060.10(3)

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=487101

Effective until 11/01/2020

Definitions

3. "Severe mental illness" means any of the following biologically based mental illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:
   a. Schizophrenia,
   b. Bipolar disorder (manic-depressive illness),
   c. Major depressive disorder,
   d. Panic disorder,
   e. Obsessive-compulsive disorder, and
   f. Schizoaffective disorder

Effective 11/01/2021

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=104390

4. Mental health and substance use disorder" means any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and
5. Mental health and substance use disorder benefits" means benefits covering items or services for mental health conditions or substance use disorders, as defined under the terms of the health benefit plan and in accordance with applicable federal and state law. Any condition defined by the plan as a mental health condition or not a mental health condition shall be consistent with the definition of that condition included in generally recognized independent standards of current medical practice, including but not limited to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders or the most recent edition of the International Classification of Disease.

Oklahoma Administrative Code Section 365:40-5-20 Health Maintenance Organizations (HMO) Basic and Supplemental Health Care Services

http://www.oar.state.ok.us/oar/codedoc02.nsf/frmMain?OpenFrameSet&Frame=Main&Src=_75tnm2shfcdnm8pb4dthj0chedppmcbq8dtmmak31ctijujrgcln50ob7ckj42tbkdt374obdcli00_

Basic health care services shall include:

(6) Twenty outpatient visits per member per year, as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services, or both

Department of Insurance, Title 36, Section 6060.11

Effective until 11/01/2020

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=487102

A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of severe mental illness.
B. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan offered, issued, or issued for delivery in this state on or after the effective date of this act may provide benefits for other forms of mental health or substance abuse disorder benefits.
C. 1. Benefits for mental health disorders, including, but not limited to those required by subsection A of this section, and for substance abuse disorder as provided in subsection B of this section shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders, including, but not limited to:
    a. Coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,
    b. Coverage of outpatient services,
    c. Coverage of medication,
    d. Maximum lifetime benefits,
    e. Copayments,
    f. Coverage of home health visits,
    g. Individual and family deductibles, and
    h. Coinsurance.
    2. Treatment limitations applicable to mental health or substance abuse disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.
D. The provisions of this section shall not apply to coverage provided by a health benefit plan for a small employer.

Section 6060.11a, Procedure When No In-Network Behavioral Health Care Provider is Available within a Timely Manner (Effective 11/1/2023)

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=494765

A. For the purposes of this act:
    1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

2. “Health care provider” or “provider” means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes; and
3. “Timely manner” means:
   a. For a request for a routine appointment, a provider’s referral for services, the start of a new treatment or medication, or other maintenance services, as determined by the Insurance Department, thirty (30) days from the date that the insured requests the appointment, service, or care,
   b. For residential care or hospitalization, seven (7) days from the date that the insured first attempts to receive care, and
   c. For urgent, emergency, or crisis care, twenty-four (24) hours from the date and time that the insured first attempts to receive care.

B. A health benefit plan must establish a documented procedure to assist a plan member in accessing an out-of-network behavioral health care provider when no in-network behavioral health care provider is available within a timely manner.

C. If the beneficiary of a health benefit plan is unable to obtain covered behavioral health services from an in-network provider in a timely manner as defined in subsection A of this section, including medically appropriate telehealth services, such plan shall ensure coverage of the behavioral health services from an out-of-network provider by arranging a network exception with a negotiated rate from an out-of-network provider. Such an agreement between the health benefit plan and the out-of-network provider shall hold the beneficiary harmless for any amount greater than the in-network cost-sharing amount, including copayment, coinsurance, and deductible, that the beneficiary would have paid had the same services been rendered by an in-network provider. The negotiated rate in the network exception, in addition to the beneficiary's in-network cost-sharing amount, shall be accepted as payment in full for the provided behavioral health services. In no instance shall the beneficiary pay more than the in-network cost-sharing amount for such services.

D. A plan shall not be held responsible if behavioral health services are available within a timely manner, as defined in this section, but the beneficiary chooses to schedule services outside the timely access standard.

E. A health benefit plan that makes a payment to an out-of-network provider pursuant to this section shall document the details of the payment to be made available to the Department upon request not later than twenty (20) days from the date requested.

F. The Department may promulgate rules to ensure compliance with and effectuate the provisions of this section.

G. The Insurance Department shall have the authority to investigate when an insurer has failed to ensure coverage as required by this section. After the conclusion of an investigation, the Department may use all available tools to levy fees or fines for noncompliance.

Section 6060.11b - Reimbursement for Mental Health or Substance Abuse Disorder Benefits (Effective 11/1/2023)

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=494766

A. For the purposes of this section:
1. “Behavioral health integration” means an approach to delivering mental health care that improves the ability for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practice pursuant to Current Procedural Terminology billing code 99484, as established by the American Medical Association;
2. “Health benefit plan” means a plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;
3. “Mental health and substance abuse disorder benefits” means benefits for the treatment of any condition or disorder that involves a mental health condition or substance abuse disorder, including, but not limited to, those that fall under any of the diagnostic categories listed in the mental disorders section of the most recent edition of the International Classification of Diseases or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;
4. “Oklahoma Medicaid Program” means the state program administered by the Oklahoma Health Care Authority pursuant to Section 1002 of Title 56 of the Oklahoma Statutes; and
5. “Psychiatric collaborative care model” means the evidence-based, integrated behavioral health service delivery method described pursuant to 81 C.F.R. 80230. The model shall include, but not be limited to, the following Current Procedural Terminology billing codes, as established by the American Medical Association:
   a. 99492,
   b. 99493, and
   c. 99494.

B. 1. Any health benefit plan that is offered, issued, or renewed in this state and that provides mental health or substance abuse disorder benefits shall provide reimbursement for such benefits that are delivered through the behavioral health integration and psychiatric collaborative care models.

2. The Oklahoma Medicaid Program shall provide reimbursement for such benefits that are delivered through the behavioral health integration and psychiatric collaborative care models.
3. Plans offered, issued, or renewed in this state that provide benefits under this subsection may deny reimbursement of any Current Procedural Terminology code pursuant to paragraph 3 of subsection A of this section due to medical necessity; provided, such medical necessity determinations shall be in compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations, and in accordance with the utilization review requirements pursuant to Section 6551 et seq. of Title 36 of the Oklahoma Statutes and the review and denial of mental health and substance abuse disorder treatments and services in Section 1250.5 et seq. of Title 36 of the Oklahoma Statutes.

Effective 11/01/2020

https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=104391

A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of mental health and substance use disorders.
B. 1. Benefits for mental health and substance use disorders shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders including, but not limited to:
   a. Coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,
   b. Coverage of outpatient services,
   c. Coverage of medication,
   d. Maximum lifetime benefits,
   e. Copayments,
   f. Coverage of home health visits,
   g. Individual and family deductibles, and
   h. Coinsurance.
   2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.
C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.
D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).
E. Beginning on or after the effective date of this act, each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an annual report to the Insurance Commissioner on or before April 1 of each year that contains the following:
   1. A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;
   2. Identification of all nonquantitative treatment limitations applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and
   3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 of this subsection and for each nonquantitative treatment limitation identified in paragraph 2 of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to and are applied no more stringently than to medical and surgical in the same classification of benefits. At a minimum, the results of the analysis shall:
      a. Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit including factors that were considered but rejected,
      b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation,
      c. Provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and

substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits,

d. Provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits in the same classification of benefits, and

e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate that the insurer is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

F. The Commissioner shall implement and enforce any applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

G. No later than June 1, 2021, and by June 1 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required in subsection E of this section, during the most recent annual cycle; provided, however, that any information that is confidential or a trade secret shall be redacted.

1. The Commissioner shall identify insurers that have failed in whole or in part to comply with the full extent of reporting required in this section and shall make a reasonable attempt to obtain missing reports or information by June 1 of the following year.
2. The reports submitted by insurers and the identification by the Commissioner of noncompliant insurers shall be made available to the public by posting on the Internet website of the Insurance Department.

H. The Commissioner shall promulgate rules pursuant to the provisions of this section and any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, that relate to the business of insurance.

Effective on 11/01/2022

Insurance Plans to Include Treatment of Severe Mental Illness - Provisions - Report - Promulgate Rules (oscn.net)

A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after January 1, 2000, shall provide benefits for treatment of mental health and substance use disorders.

B. 1. Benefits for mental health and substance use disorders shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders including, but not limited to:

a. Coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,
b. Coverage of outpatient services,
c. Coverage of medication,
d. Maximum lifetime benefits,
e. Copayments,
f. Coverage of home health visits,
g. Individual and family deductibles, and
h. Coinsurance.

2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.

C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.

D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

E. Beginning on or after January 1, 2000, each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder benefits shall submit an annual report to the Insurance Commissioner on or before April 1 of each year that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;
2. Identification of all nonquantitative treatment limitations applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and
3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 of this subsection and for each nonquantitative treatment limitation identified in paragraph 2 of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to and are applied no more stringently than to medical and surgical benefits in the same classification of benefits. At a minimum, the results of the analysis shall:
    a. Identify and clearly define the factors and terms used to determine that a nonquantitative treatment limitation will apply to a benefit ,
    b. Identify and clearly define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation,
    c. Provide the detailed, written, and reasoned comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits,
    d. Provide the detailed, written, and reasoned comparative analyses including the results of the analyses performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits in the same classification of benefits, and
    e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate whether the insurer is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations including 45 CFR 146.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

F. The findings and conclusions shall include sufficient detail to fully explain such findings including methodologies for the analyses, detailed descriptions of each treatment limitation for mental health and substance use disorder benefits compared to each treatment limitation for medical and surgical benefits, and detailed descriptions of all criteria involved for approving mental health and substance use disorder benefits as compared to the criteria involved for approving medical and surgical benefits.

G. The Commissioner shall implement and enforce any applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, 45 CFR 156.115(a)(3), 42 U.S.C. 300gg-26(a), 29 U.S.C. 1185a(a), and 26 U.S.C. 9812.

H. The Commissioner shall issue guidance and standardized reporting templates to ensure compliance with the provisions of this section. Guidance shall include examples of non-quantitative treatment limitations as identified by the Centers for Medicare and Medicaid Services, the Department of Labor, and the Employee Benefits Security Administration.

I. No later than December 31, 2021, and by December 31 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required in subsection E of this section, during the most recent annual cycle.
    1. The Commissioner shall identify insurers that have failed in whole or in part to comply with the full extent of reporting required in this section and shall make a reasonable attempt to obtain missing reports or information by June 1 of the following year.
    2. The reports submitted by insurers and the identification by the Commissioner of noncompliant insurers shall be made available to the public by posting on the Internet website of the Insurance Department. Any information that is confidential or a trade secret shall be redacted prior to the public posting.

J. The Commissioner may promulgate rules pursuant to the provisions of this section and any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, that relate to the business of insurance.

Oklahoma Statute Section 43A-1-103 Mental Health Law, Definitions

https://law.justia.com/codes/oklahoma/2019/title-43a/section-43a-1-103/

3. "Mental illness" means a substantial disorder of thought, mood, perception, psychological orientation or memory that significantly impairs judgment, behavior, and capacity to recognize reality or ability to meet the ordinary demands of life.

7. "Facility" means any hospital, school, building, house or retreat, authorized by law to have the care, treatment or custody of an individual with mental illness, or drug or alcohol dependency, gambling addiction, eating disorders, an opioid substitution treatment program, including, but not limited to, public or private hospitals, community mental health centers, clinics, satellites or facilities; provided, that facility shall not mean a child guidance center operated by the State Department of Health;

11. "Licensed mental health professional" means:
    a. A Psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,
    b. A psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry,
    c. A physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act,
    d. A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists,
    e. A professional counselor licensed pursuant to the Licensed Professional Counselors Act,
    f. A person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act,
    g. A licensed marital and family therapist as defined in the Marital and Family Therapist Licensure Act,
    h. A licensed behavioral practitioner as defined in the Licensed Behavioral Practitioner Act,
    i. An advanced practice nurse as defined in the Oklahoma Nursing Practice Act,
    j. A physician's assistant who is licensed in good standing in this state, or
    k. A licensed drug and alcohol counselor/mental health ("LADC/MH") as defined in the Licensed Alcohol and Drug Counselors Act
13. a. "Person requiring treatment" means a person who because of his or her mental illness or drug or alcohol dependency:
        (1) Poses a substantial risk of immediate physical harm to self as manifested by evidence or serious threats of or attempts at suicide or other significant self-inflicted bodily harm,
        (2) Poses a substantial risk of immediate physical harm to another person or persons as manifested by evidence of violent behavior directed toward another person or persons,
        (3) Has placed another person or persons in a reasonable fear of violent behavior directed towards such person or persons or serious physical harm to them as manifested by serious and immediate threats,
        (4) Is in a condition of severe deterioration such that, without immediate intervention, there exists a substantial risk that severe impairment or injury will result to the person, or
        (5) Poses a substantial risk of immediate serious physical injury to self or death as manifested by evidence that the person is unable to provide for and is not providing for his or her basic physical needs.
    b. The mental health or substance abuse history of the person may be used as part of the evidence to determine whether the person is a person requiring treatment or an assisted outpatient. The mental health or substance abuse history of the person shall not be the sole basis for this determination.
    c. Unless a person also meets the criteria established in subparagraph a or b of this paragraph, person requiring treatment or an assisted outpatient shall not mean:
        1. A person whose mental processes have been weakened or impaired by reason of advanced years, dementia, or Alzheimer's disease,
        2. A mentally retarded or developmentally disabled person as defined in Title 10 of the Oklahoma Statutes,
        3. A person with seizure disorder,
        4. A person with a traumatic brain injury, or
        5. A person who is homeless.

    A person who meets the criteria established in this section, but who is medically unstable, or the facility holding the person is unable to treat the additional medical conditions of that person should be discharged and transported in accordance with Section 1-110 of this title;

17. "Individualized treatment plan" means a proposal developed during the stay of an individual in a facility, under the provisions of this title, which is specifically tailored to the treatment needs of the individual. Each plan shall clearly include the following:
    a. A statement of treatment goals or objectives, based upon and related to a clinical evaluation, which can be reasonably achieved within a designated time interval,

b. Treatment methods and procedures to be used to obtain these goals, which methods and procedures are related to each of these goals and which include specific prognosis for achieving each of these goals,
c. Identification of the types of professional personnel who will carry out the treatment procedures, including appropriate medical or other professional involvement by a physician or other health professional properly qualified to fulfill legal requirements mandated under state and federal law,
d. Documentation of involvement by the individual receiving treatment and, if applicable, the accordance of the individual with the treatment plan, and
e. A statement attesting that the executive director of the facility or clinical director has made a reasonable effort to meet the plan's individualized treatment goals in the least restrictive environment possible closest to the home community of the individual;

18. “Telemedicine” means the practice of health care delivery, diagnosis, consultation, evaluation, treatment, transfer of medical data, or exchange of medical education information by means of audio, video, or data communications. Telemedicine uses audio and video multimedia telecommunication equipment which permits two-way real-time communication between a health care practitioner and a patient who are not in the same physical location. Telemedicine shall not include consultation provided by telephone or facsimile machine.

19. "Recovery and recovery support" means nonclinical services that assist individuals and families to recover from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, including but not limited to transportation to and from treatment or employment, employment services and job training, case management and individual services coordination, life skills education, relapse prevention, housing assistance, child care, and substance abuse education;
20. "Assisted outpatient" means a person who:
    a. Is either currently under the care of a facility certified by the Department of Mental Health and Substance Abuse Services as a Community Mental Health Center, or is being discharged from the custody of the Oklahoma Department of Corrections, or is being discharged from a residential placement by the Office of Juvenile Affairs,
    b. Is suffering from a mental illness,
    c. Is unlikely to survive safely in the community without supervision, based on a clinical determination,
    d. Has a history of lack of compliance with treatment for mental illness that has:
        (1) Prior to the filing of a petition, at least twice within the last thirty-six (36) months been a significant factor in necessitating hospitalization or treatment in a hospital or residential facility, including admission to a community-based structured crisis center as certified by the Oklahoma Department of Mental Health and Substance Abuse Services, or receipt of services in a forensic or other mental health unit of a correctional facility, or a specialized treatment plan for treatment of mental illness in a secure juvenile facility or placement in a specialized residential program for juveniles, or
        (2) Prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last twenty-four (24) months,
    e. Is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community,
    f. In view of his or her treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the person or persons as defined in this section, and
    g. Is likely to benefit from assisted outpatient treatment; and
21. "Assisted outpatient treatment" means outpatient services which have been ordered by the court pursuant to a treatment plan approved by the court to treat an assisted outpatient's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

Section 365:40-5-20 Basic Health Care Services

https://www.oid.ok.gov/wp-content/uploads/2019/10/091517_C40S5.pdf

Basic health care services shall include:

(7) Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs, including
    (A) Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs including detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health care services for the treatment of other medical conditions.

Section 365:40-5-21 Supplemental Health Care Services

https://www.oid.ok.gov/wp-content/uploads/2019/10/091517_C40S5.pdf

Supplemental health care services of an HMO may include the following:

(4) Mental health services not included as a basic health care service.

Senate Bill (SB) 254-Behavioral Health, Out-of-Network Services-Payments-Codification, Effective 11/01/2023

https://legiscan.com/OK/text/SB254/id/2790185/Oklahoma-2023-SB254-Engrossed.pdf

Section 1, New Law

A new section of law to be codified in the Oklahoma Statutes as Section 6060.11a of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purposes of this act:
   1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;
   2. "Health care provider" or "provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes; and
   3. "Timely manner" means:
      a. For a request for a routine appointment, a provider's referral for services, the start of a new treatment or medication, or other maintenance services, as determined by the Insurance Department, thirty (30) days from the date that the insured requests the appointment, service, or care,
      b. For residential care or hospitalization, seven (7) days from the date that the insured first attempts to receive care, and
      c. For urgent, emergency, or crisis care, twenty-four (24) hours from the date and time that the insured first attempts t to receive care.

B. A health benefit plan must establish a documented procedure to assist a plan member in accessing an out-of-network behavioral health care provider when no in-network behavioral health care provider is available within a timely manner.

C. If the beneficiary of a health benefit plan is unable to obtain covered behavioral health services from an in-network provider in a timely manner as defined in subsection A of this section, including medically appropriate telehealth services, such plan shall ensure coverage of the behavioral health services from an out-of-network provider by arranging a network exception with a negotiated rate from an out-of-network provider. Such an agreement between the health benefit plan and the out-of-network provider shall hold the beneficiary harmless for any amount greater than the in-network cost-sharing amount, including copayment, coinsurance, and deductible, that the beneficiary would have paid had the same services been rendered by an in-network provider. The negotiated rate in the network exception, in addition to the beneficiary's in network cost-sharing amount, shall be accepted as payment in full for the provided behavioral health services. In no instance shall the beneficiary pay more than the in-network cost-sharing amount for such services.

D. A plan shall not be held responsible if behavioral health services are available within a timely manner, as defined in this section, but the beneficiary chooses to schedule services outside the timely access standard.

E. A health benefit plan that makes a payment to an out-of-network provider pursuant to this section shall document the details of the payment to be made available to the Department upon request not later than twenty (20) days from the date requested.

F. The Department may promulgate rules to ensure compliance with and effectuate the provisions of this section.

G. The Insurance Department shall have the authority to investigate when an insurer has failed to ensure coverage as required by this section. After the conclusion of an investigation, the Department may use all available tools to levy fees or fines for noncompliance.

Section 2

This act shall become effective November 1, 2023.

Oregon

Health Plan Note: For more specific mandated requirements, see OAR 836-053-1325 Procedures for Conducting Independent Reviews, 836-053-1330 Criteria and Consideration for Independent Review Determinations.

Section 743A.168 Treatment of Chemical Dependency, Including Alcoholism, and Mental or Nervous Conditions; Qualified Providers, Rules

https://www.oregonlaws.org/ors/743A.168

Section 743A.168 Behavioral Health Treatment; Qualified Providers, Rules

(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) "Facility" means a corporate or governmental entity or other provider of services for the treatment of behavioral health conditions.
- (e) "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.
- (f) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.
- (g) "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) "Prior authorization" has the meaning given that term in ORS 743B.001.
- (i) "Program" means a particular type or level of service that is organizationally distinct within a facility.
- (j) "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 health insurer or an issuer of an individual health benefit plan that is not a grandfathered health plan as defined in ORS 743B.005 and is otherwise eligible to receive reimbursement for coverage under the policy;
  - (B) A health care facility as defined in ORS 433.060;
  - (C) A residential facility as defined in ORS 430.010;
  - (D) A day or partial hospitalization program;
  - (E) An outpatient service as defined in ORS 430.010; or
  - (F) A provider organization certified by the Oregon Health Authority under subsection (9) of this section.
- (k) "Relevant clinical specialties" includes but is not limited to:
  - (A) Psychiatry;
  - (B) Psychology;
  - (C) Clinical sociology;
  - (D) Addiction medicine and counseling; and
  - (E) Behavioral health treatment.
- (l) "Standards of care and clinical practice guidelines" includes but is not limited to:
  - (A) Patient placement criteria;
  - (B) Recommendations of agencies of the federal government; and
  - (C) Drug labeling approved by the United States Food and Drug Administration.
- (m) "Utilization review" has the meaning given that term in ORS 743B.001.
- (n) "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.

(2) A group health insurance policy or an individual health benefit plan that is not a grandfathered health plan providing coverage for hospital or 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 to a lower level of care;
  (C) Treatment of co-occurring behavioral health conditions or medical conditions in a coordinated manner;
  (D) Treatment at the least intensive and least restrictive level of care that is safe and most effective and meets the needs of the insured's condition;
  (E) A lower level or less intensive care only if it is comparably as safe and effective as treatment at a higher level of service or intensity;
  (F) Treatment to maintain functioning or prevent deterioration;
  (G) Treatment for an appropriate duration based on the insured's particular needs;
  (H) Treatment appropriate to the unique needs of children and adolescents;
  (I) Treatment appropriate to the unique needs of older adults; and
  (J) Coordinated care and case management as defined by the Department of Consumer and Business Services by rule.

(d) 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.

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

(f) A provider is eligible for reimbursement under this section if:
  (A) The provider is approved or certified by the Oregon Health Authority;
  (B) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities;
  (C) 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.

(g) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan 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.

(h) A group health insurer or an issuer of an individual health benefit plan other than a grandfathered health plan 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.

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

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

(k) (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, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer or issuer of an individual health benefit plan may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either staff of a group health insurer or issuer of an individual health benefit plan or personnel under contract to the group health insurer or issuer of an individual health benefit plan that is not a grandfathered health plan, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

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

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

(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 and issuers of individual health benefit plans that are not grandfathered health plans shall permit 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 and issuers of individual health benefit plans that are not grandfathered health plans shall provide a timely 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 individual 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. [Formerly 743.556; 2009 c.442 §47; 2009 c.549 §11; 2013 c.375 §1; 2013 c.581 §1; 2013 c.681 §62; 2016 c.11 §7; 2017 c.6 §29; 2017 c.17 §57; 2017 c.273 §5; 2017 c.409 §35; 2019 c.284 §6; 2019 c.285 §5; 2021 c.629 §§5,8]

Oregon Administrative Rules (OAR) Section 836-053-1404 (Effective to 12/31/2022)

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204610

a. As used in ORS 743A.168, this rule and OAR 836:
   (1) "Mental or nervous conditions" means any mental disorder covered by diagnostic categories listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV) or the "Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition" (DSM-5).
   (2) "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.
   (3) "Chemical dependency" does not mean an addiction to, or dependency on:
      (a) Tobacco;
      (b) Tobacco products; or
      (c) Foods
b. A non-contracting provider must cooperate with a group health insurer's requirements for review of treatment in ORS 743A.168(10) and (11) to the same extent as a contracting provider in order to be eligible for reimbursement.
c. The exception of a disorder in the definition of "mental or nervous conditions" or "chemical dependency" in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

Stat. Auth.: ORS 731.244 & 743A.168
Stats. Implemented: ORS 743A.168
Hist.: ID 13-2006, f. 7-14-06 cert. ef. 1-1-07; ID 19-2012(Temp), f. & cert. ef. 12-20-12 thru 6-17-13; ID 3-2013, f. 6-10-13, cert. ef. 6-17-13; ID 19-2014(Temp), f. & cert. ef. 11-14-14 thru 5-12-15; ID 3-2015, f. & cert. ef. 5-12-15 ID 14-2015(Temp), f. & cert. ef. 12-17-15 thru 5-1-16; ID 5-2016, f. & cert. ef. 4-26-16

Oregon Administrative Rules (OAR) Section 836-053-1404 Definitions, Noncontracting Providers, Co-Morbidity Disorders (Effective 01/01/2023)

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204610

(1) As used in ORS 743A.168 and OAR Chapter 836:
   (a) “Behavioral health condition” means any mental or substance use disorder covered by diagnostic categories listed in the 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) “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.
   © “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;
      © Specialty societies.
(2) A non-contracting provider must cooperate with a health insurer’s requirements for review of treatment in ORS 743A.168(2) and (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 “behavioral health condition” in section (1) of this rule does not include or extend to a co-morbidity disorder accompanying the excepted disorder.

OAR 836-053-1405-General Requirements for Coverage of Behavioral Health Conditions (Effective 01/01/2013)

https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=q8n69QdU7gD04wTCTak5hBKW9iQC11wS7B_z8BOq1oylRqzsKmQu!-1878043812?ruleVrsnRsn=204617

(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 of behavioral health conditions, including but not limited to prescription drugs, at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement for medically necessary treatment for medical 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 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 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 conditions, regardless of whether such drugs are intended to treat behavioral health conditions or medical 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.

(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.

(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 health conditions.

(5) 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 and behavioral health conditions.

(6) Subject to subsection (5) of ORS 743A.168 and OAR 836-053-1405(7) through (12) coverage for expenses arising from treatment for behavioral health conditions 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 a medical 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) 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; or
   (b) Treatment criteria guidelines developed by the nonprofit professional association for the relevant clinical specialty.

(8) 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) Any medical necessity, utilization or other clinical review relating to level of care placement decisions must be based on:
  (a) The current generally accepted standards of care; and
  (b) The version available in 2021 of the levels of care placement criteria developed by the nonprofit professional association for the relevant clinical specialty.
(10) 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 are based on the generally accepted standards of care, and may include advancements in technology of types of care. Other criteria utilized must be made available to the department upon request.
(11) For purposes of medical necessity, utilization or other clinical review relating to level of care placement decisions the following guidelines or criteria 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 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).
(12) 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.
(13) 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.
(14) A group health insurer or an individual health benefit 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.
(15) 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.
(16) 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 "behavioral health condition" in OAR 836-053-1404.
(17) 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 and behavioral health conditions.

OAR Section 836-053-1407

Prohibited Exclusions

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204623

1. An insurer may not deny benefits for a medically necessary treatment or service for a mental or nervous condition based solely upon:
   a. The enrollee's interruption of or failure to complete a prior course of treatment;
   b. The enrollee's categorical exclusion of such treatment or service when applied to a class of mental or nervous conditions; or
   c. The fact that a court ordered the enrollee to receive or obtain the treatment or service for a mental or nervous 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 enrollee'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 member 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.

OAR Section 836-053-1408

Required Disclosures

https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=204624

1. Insurers must provide an enrollee's or an enrollee's authorized representative reasonable access to and copies of all documents, records, and other information relevant to an member's claim or request for coverage.
2. Insurers must provide the criteria, processes, standards and other factors used to make medical necessity determinations of benefits for mental or nervous conditions. This information must be made available free of charge by the insurer to any current 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

OR SB628 Relating to Pediatric Mental Health Disorders (Effective Date 01/01/2024)

https://legiscan.com/OR/text/SB628/id/2627794/Oregon-2023-SB628-Introduced.pdf

Requires health benefit plan and health care service contract coverage of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome.

Relating to pediatric mental health disorders; creating new provisions; and amending ORS 750.055 Be It Enacted by the People of the State of Oregon:

Section 1

Sections 2 and 3 of this 2023 Act are added to and made a part of the Insurance Code.

Section 2

(1) A health benefit plan, as defined in ORS 743B.005, must cover the cost of treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including but not limited to intravenous immunoglobulin therapy and plasmapheresis.
(2) This section is exempt from ORS 743A.001.

Section 3

For billing and diagnostic purposes, the coverage described in section 2 of this 2023 Act may be coded as autoimmune encephalitis until the American Medical Association and the Centers for Medicare and Medicaid Services create and assign a specific billing and diagnostic code for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome.

Section 4

ORS 750.055, as amended by section 11, chapter 37, Oregon Laws 2022, is amended to read:

(1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:
   (a) ORS 705.137, 705.138 and 705.139.
   (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.
   (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.
   (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.
   (e) ORS 734.014 to 734.440.
   (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.
   (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.
   (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2, chapter 771, Oregon Laws 2013, and sections 6 and 7, chapter 37, Oregon Laws 2022, and section 2 of this 2023 Act.
   (i) ORS [743.025,] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800.
   (j) The following provisions of ORS chapter 744:
      (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;
      (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and
      (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.
   (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:
   (a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.
   (b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(3) For the purposes of this section, health care service contractors are insurers.

(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(5) (a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.
   (b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

Section 5

ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017,

section 6, chapter 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, and section 12, chapter 37, Oregon Laws 2022, is amended to read:

(1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:
   (a) ORS 705.137, 705.138 and 705.139.
   (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.
   (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582.
   (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.
   (e) ORS 734.014 to 734.440.
   (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.
   (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790 and section 8, chapter 37, Oregon Laws 2022.
   (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and sections 6 and 7, chapter 37, Oregon Laws 2022, and section 2 of this 2023 Act.
   (i) ORS [743.025,] 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800.
   (j) The following provisions of ORS chapter 744:
      (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;
      (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and
      (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.
   (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:
   (a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.
   (b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(3) For the purposes of this section, health care service contractors are insurers.

(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(5) (a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.
   (b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
and 750.045 that are necessary for the proper administration of these provisions.

Section 6

Section 2 of this 2023 Act and the amendments to ORS 750.055 by sections 4 and 5 of this 2023 Act apply to health benefit plans and health care service contracts issued, renewed or extended on or after the effective date of this 2023 Act.

Section 7

Section 3 of this 2023 Act is repealed on January 2, 2028.

Texas

The complete text can be accessed at: http://www.statutes.legis.state.tx.us/Docs/IN/htm/IN.1355.htm

Washington

Mental Health Legislation WAC 284-43-7000 through 284-43-7120

The complete text can be accessed at: http://app.leg.wa.gov/WAC/default.aspx?dispo=true&cite=284-43

RCW Section 48.21.241 Mental Health Services, Group health Plans, Definition, Coverage Required, When

https://app.leg.wa.gov/rcw/default.aspx?cite=48.21.241

Effective 01/01/2021

(1) For the purposes of this section, "mental health services" means:
   (a) For health benefit plans that provide coverage for medical and surgical services issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary; and
   (b) For health benefit plans that provide coverage for medical and surgical services issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) All group disability insurance contracts and blanket disability insurance contracts providing health benefit plans that provide coverage for medical and surgical services shall provide coverage for:
   (a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
   (b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

Effective until 01/01/2020

1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a)

Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the insurer's medical director or designee determines the treatment to be medically necessary.

2) All group disability insurance contracts and blanket disability insurance contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:
   (a) For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, coverage for:
      i. Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and
      ii. Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (b) For all group health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:
      i. Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and
      ii Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (c) For all group health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, coverage for:
      i. Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
      ii. Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.
4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.
5) Nothing in this section shall be construed to prevent the management of mental health services.

If offered must meet:

RCW Section 48.43.091 Health Carrier Coverage of Outpatient Mental Health Services

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.091

1. Requirements: Every health carrier that provides coverage for any outpatient mental health service shall comply with the following requirements:
   a. In performing a utilization review of mental health services for a specific enrollee the utilization review is limited to accessing only the specific health care information contained in the enrollee's record.
   b. In performing an audit of a provider that has furnished mental health services to a carrier's enrollee's the audit is limited to accessing only the records of enrollee's covered by the specific health carrier for which the audit is being performed, except as otherwise permitted by RCW 70.02.050 and 71.05.630.

RCW Section 41.05.600 Mental Health Services-Definition

https://app.leg.wa.gov/rcw/default.aspx?cite=41.05.600

Effective until 01/01/2020

Coverage required when (HB 1154. New sections added. Applies to health insurance policies issued or renewed on or after 01/01/2006; Only applies to large group (51+ employees); however, HB 1460, which was enacted in 2007 expands coverage to individual.

1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the administrator by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary.
2) All health benefit plans offered to public employees and their covered dependents under this chapter that provide coverage for medical and surgical services shall provide:
   (a) For all health benefit plans established or renewed on or after January 1, 2006, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (b) For all health benefit plans established or renewed on or after January 1, 2008, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (c) For all health benefit plans established or renewed on or after July 1, 2010, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.
4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.
5) Nothing in this section shall be construed to prevent the management of mental health services.
6) The administrator will consider care management techniques for mental health services, including but not limited to: (a) Authorized treatment plans; (b) preauthorization requirements based on the type of service; (c) concurrent and

retrospective utilization review; (d) utilization management practices; (e) discharge coordination and planning; and (f) contracting with and using a network of participating providers.

Effective 01/01/2021

(1) For the purposes of this section, "mental health services" means:
   (a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the director by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the authority's or contracted insuring entity's medical director determines the treatment to be medically necessary; and
   (b) For health benefit plans issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the director by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) All health benefit plans offered to public employees and their covered dependents under this chapter that provide coverage for medical and surgical services shall provide coverage for:
   (a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
   (b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health.

(5) The director will consider care management techniques for mental health services if a comparable benefit management requirement is applicable to medical and surgical services, including but not limited to: (a) Authorized treatment plans; (b) preauthorization requirements based on the type of service; (c) concurrent and retrospective utilization review; (d) utilization management practices; (e) discharge coordination and planning; and (f) contracting with and using a network of participating providers.

RCW 48.46.291 Mental Health Services, Health Plans Definition-Coverage Required, When

(HB 1460. New sections added to expand coverage to individual and small group insurance markets issued or renewed on or after 1/1/08)
https://app.leg.wa.gov/rcw/default.aspx?cite=48.46.291

Effective Until 01/01/2020

1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary.

2) All health benefit plans offered by health maintenance organizations that provide coverage for medical and surgical services shall provide:
   (a) For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (b) For all health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   (c) For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.
4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.
5) Nothing in this section shall be construed to prevent the management of mental health services.

Effective 01/01/2021

(1) For the purposes of this section, "mental health services" means:
   (a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary; and
   (b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) A health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, offered by health maintenance organizations that provide coverage for medical and surgical services shall provide coverage for:
   (a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
   (b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.
(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

RCW 48.44.341 Mental Health Services, Health plans, Definition, Coverage Required, When

https://app.leg.wa.gov/rcw/default.aspx?cite=48.44.341

Effective until 01/01/2020

1) For the purposes of this section, "mental health services" means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary.
2) All health service contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:
   a. For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   b. For all health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2008, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services; and
      (ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
   c. For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, coverage for:
      (i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or

other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

3) In meeting the requirements of subsection (2)(a) and (b) of this section, health benefit plans may not reduce the number of mental health outpatient visits or mental health inpatient days below the level in effect on July 1, 2002.
4) This section does not prohibit a requirement that mental health services be medically necessary as determined by the medical director or designee, if a comparable requirement is applicable to medical and surgical services.
5) Nothing in this section shall be construed to prevent the management of mental health services.

Effective 01/01/2021

(1) For the purposes of this section, "mental health services" means:
   (a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the health care service contractor's medical director or designee determines the treatment to be medically necessary; and
   (b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.
(2) A health service contract or a plan deemed by the commissioner to have a short-term limited purpose or duration, providing health benefit plans that provide coverage for medical and surgical services shall provide coverage for:
   (a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and
   (b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.
(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.
(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services.

State Market Plan Enhancements

Some members may have additional inpatient mental health benefits. For member specific coverage and limitations for inpatient mental health benefit, refer to the member's EOC/SOB to determine coverage eligibility or contact the Customer Service Department.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility.

Not Covered

Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) to determine coverage eligibility and exclusions.

References

Mental Health Parity Act of 1996

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
08/01/2024	All	**Supporting Information** • Archived previous policy version BIP101.K

	Oklahoma	**Federal/State Mandated Regulations**
		• Added language pertaining to *Oklahoma Administrative Code*:
		  ○ *Section 6060.11a*
		  ○ *Section 6060.11b*

	Oregon	**Federal/State Mandated Regulations**
		• Revised language pertaining to:
		  ○ *Oregon Revised Statute Section 743A.168*
		  ○ *Oregon Administrative Rules*:
		  ▪ *Section 836-053-1404*
		  ▪ *Section 836-053-1405*
		• Added language pertaining to *Oregon Senate Bill 628*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.