Report on Behavioral Health Parity

As required by House Bill 3046 (2021)

DCBS | Department of Consumer and Business Services

Sept. 15, 2023

About DCBS:
The Department of Consumer and Business Services (DCBS) is Oregon's largest consumer protection and business regulatory agency. For more information, visit dcbs.oregon.gov.

About Oregon DFR:
The Division of Financial Regulation (DFR) protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and services, and is part of DCBS. Visit dfr.oregon.gov.

Additional report information:
This report is based on data reported by insurance companies to the Division of Financial Regulation (DFR) through March 2023, covering the 2022 calendar year.

Acknowledgments

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Executive summary

In the two years since implementation of Oregon Revised Statute (OARS) 743A.168, Oregon remains steadfast in its commitment to enhancing access to behavioral health and substance use disorder treatment services. While we are still working toward achieving marked improvements, we are actively collaborating with insurers to improve access to care. However, significant challenges persist. The analysis conducted for this reporting year by the Department of Consumer and Business Services (DCBS) Division of Financial Regulation (DFR) has brought forth several key findings that provide insights into the state of behavioral health coverage and treatment services.

Among these findings are:

- **Claim denial rates**: In 2022, there was a moderate change in claim denial rates from the previous year. Behavioral health benefits saw a decrease in denial rates, dropping from 8.76 percent in 2021 to 6.59 percent in 2022. In contrast, denial rates for medical-surgical benefits rose from 8.77 percent in 2021 to 12.53 percent in 2022. Despite these shifts, significant variation persists across insurers, with some denying behavioral health claims at a higher frequency.
- **Provider reimbursement rates**: Reimbursement rates for behavioral health providers are reported to be consistently lower than those for medical-surgical providers, even for office visits of equivalent length. This is evident across provider types and specific Current Procedural Terminology (CPT) codes. For example, the data reveals an average difference of approximately $91.60 in the median reimbursement rates for a psychotherapy visit with a behavioral health provider compared to an office visit with a medical-surgical provider.

  Carrier narrative reports identified factors that may affect provider reimbursement rates:

  - Rates for a given CPT code may vary based on executed contracts with the provider and according to the provider type.

- Geographic market (market rate and payment type for provider type and/or specialty).
- Type of provider (i.e. hospital, clinic and practitioner) and/or specialty.
- Training, experience and licensure of provider.

- **Nonquantitative treatment limits (NQTLs)**: An NQTL is a limit on the amount, duration, or scope of behavioral health or substance use disorder benefits not quantified by specific numbers of visits, days, or units of service. Insurers reported that NQTLs were applied uniformly to both behavioral health and medical-surgical benefits. However, the data supplied by insurers could not confirm parity in application or discern how stringently an NQTL may apply to behavioral health benefits.
- **Evidentiary standards**: Evidentiary standards refer to the criteria and procedures that insurers must follow to substantiate their policy decisions, such as benefit limitations or exclusions. These standards may rely on medical evidence, expert opinions, or other relevant information. While insurers report compliance with the mandated evidentiary standards, the inconsistent use of various sources and methodologies suggests a need for greater clarity and uniformity in application.
- **Out-of-network claims**: Behavioral health claims had a higher percentage (10.68 percent) of being paid to out-of-network providers compared to medical-surgical claims (4.03 percent). This suggests that individuals seeking behavioral health services may face difficulties in accessing in-network providers, or they may consciously choose out-of-network care for reasons such as availability or preference.
- **In-network claims**: Despite the above challenges, the data shows a marked increase in the proportion of behavioral health claims being settled with in-network providers – climbing from 83.71 percent in 2021 to 89.33 percent in 2022. This upward trend may indicate either enhanced availability and quality of in-network behavioral health services or a boost in consumer confidence in using these in-network options.
- **Telehealth utilization**: Across all insurance providers, behavioral health services consistently demonstrated greater utilization of telehealth compared to medical-surgical services. This trend strongly suggests that telehealth is becoming an increasingly prevalent method in the delivery of behavioral health care, while its use in medical-surgical care remains less widespread.

DFR recognizes the complexity and importance of ensuring parity in behavioral health. The department's goal is to drive improvements in reporting and promote adherence to behavioral health parity requirements. The division is committed to working closely with insurers and stakeholders to enhance data gathering, foster collaboration and understanding, and ensure parity in behavioral health.

Introduction

Purpose of the report

This report is prepared under the requirements of House Bill 3046 (2021), which mandates DCBS to report annually to the legislative assembly data related to behavioral health. This report presents the findings of the analysis of the information reported by insurers offering health benefit plans in Oregon that provide behavioral health benefits. This report assesses the compliance of insurers with the requirements of ORS 743A.168 the administrative rules issued thereunder identifies any disparities in coverage of behavioral health and substance use disorder treatment and services as compared to medical or surgical treatments or services.

Methodology

The data collection process for this report involved several steps to ensure the accuracy and completeness of the findings. DFR implemented a rigorous data collection process that started with gathering information from multiple sources, such as insurers' self-reported data, consumer complaints, and feedback from providers. The department also collaborated with other state and federal agencies, including the National Association of Insurance Commissioners (NAIC), to ensure the accuracy and completeness of the data. The department also met with insurers individually to address their specific concerns with the report. This step helped refine the specific data fields to base better information on system programming differences. The information reported by insurers was reviewed and analyzed to assess their compliance with the requirements of ORS 743A.168. The findings of this report are based on the data collected and analyzed by the department.

Background

Access to behavioral health services is a significant concern in Oregon. A report by Mental Health America,[1] based on survey data collected from all 50 states and the District of Columbia, ranks Oregon 50th out of 51 jurisdictions for behavioral health care accessibility. A 50th rank signifies that Oregon has among the least available behavioral health services in the United States.

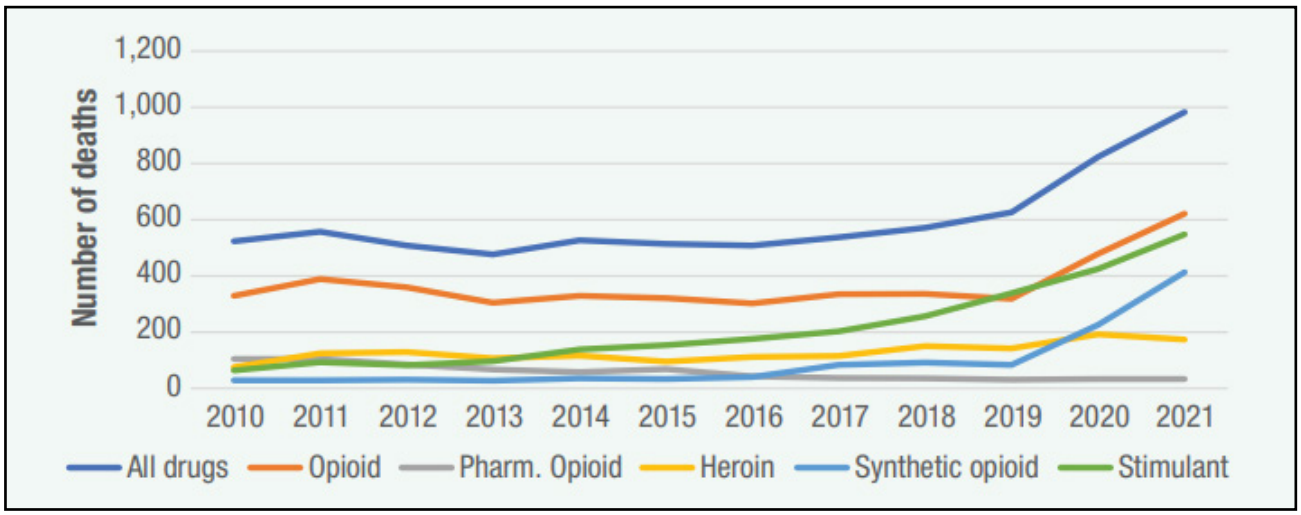
The indicators that most affected Oregon's overall ranking were its low performance in the following key behavioral health areas: adults with any behavioral illness (27.33 percent, ranking second to last at 50), youth with a severe major depressive episode (MDE) (19 percent, also ranked second to last at 50), and adults with serious thoughts of suicide (6.8 percent, similarly ranked second to last at 50).[2]

A 2023 Oregon Health Care Workforce Reporting Program report[3] includes key insights that in 2022 licensed behavioral health professionals were the largest specialty health care provider group with 13,919 licensees actively practicing; however, behavioral health professionals are concentrated in Multnomah County and relatively underrepresented throughout the rest of the state.

Additionally, a recent survey conducted by the Kaiser Family Foundation found that 35.3 percent of adults in Oregon reported symptoms of anxiety and/or depressive disorder, compared to 32.3 percent of adults in the U.S.[4]

Substance use disorder has also been a growing concern in Oregon with overdose deaths increasing significantly in recent years. According to the Oregon Health Authority, there were 1,439 overdose deaths in Oregon in 2020, a 31 percent increase from the previous year.[5] The majority of these were attributed to synthetic opioids such as fentanyl.

Figure 1: Drug overdose deaths, Oregon 2010-2021



[1] Mental Health America. (2023). The State of Mental Health in America. Accessed June 8, 2023.
[2] Ibid.
[3] 2022 Oregon's Licensed Health Care Workforce Supply. Based on data collected from 2014 through January 2022. (2023). https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/HWRP_Supply_2022_final.pdf
[4] Kaiser Family Foundation. (2021). Mental Health and Substance Use State Fact Sheets: Oregon.
[5] Oregon Health Authority. (2022). Drug Overdose Death Data. Accessed June 8, 2023.

Access to substance use disorder treatment is also a crucial issue in Oregon, as many people struggling with substance use disorder may not receive adequate care. According to the National Survey of Substance Abuse Treatment Services, in 2020, 70 percent of Oregon's treatment facilities reported a waiting list for substance use disorder treatment.[6] Also, rural areas of the state have fewer substance use disorder treatment providers per capita than urban areas, with some counties having as few as 10 substance use disorder treatment providers per 100,000 people.

These challenges underscore the importance of behavioral health parity legislation. Before the enactment of parity laws, many health plans restricted access to behavioral health services with limits on annual outpatient visits, number of inpatient days, and higher cost-sharing attributed to accessing these services. These issues and others prompted Congress to enact legislation to address parity between behavioral health coverage and medical-surgical coverage.

Federal legislation

The Mental Health Parity Act (MHPA) of 1996[7] was the first major federal initiative to address behavioral health coverage in group health plans. Under MHPA, group health plans could not impose lower lifetime coverage limits on behavioral health benefits than on medical benefits. While this law expanded coverage, insurers in many cases opted to increase co-pays, co-insurance, and deductibles, resulting in a reduction of actual coverage provided. The law also did not address substance use disorder treatment coverage. The original law expired in 2001, but was extended several times, until the law was expanded in 2007 to include more consumer protections.[8]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 preserved the MHPA protections and added new protections that included the requirement to treat substance use disorder benefits the same as behavioral health benefits, and the requirement for parity with medical benefits for all cost-sharing levels, including co-pays, co-insurance, and deductibles.[9] MHPAEA also extended the parity requirements beyond group insurance plans to include issuers of nongroup or individual plans (small group plans for employers with fewer than 50 employees remain exempt). MHPAEA does not require that plans cover behavioral health and substance use disorder treatments, only that if a plan covers treatment, that treatment be covered at parity to other benefits.

Additionally, it is pertinent to note the impact of the Affordable Care Act (ACA), specifically the Essential Health Benefits (EHB) provision. Unlike MHPAEA, the ACA affirmatively requires coverage for behavioral health and substance use disorder treatment in individual and small group plans subject to EHB. This complements the parity requirements of the MHPAEA by ensuring not just equal treatment but also coverage availability.[10]

In 2021, Congress enacted compliance provisions for the MHPAEA through the Consolidated Appropriations Act, requiring insurers to report comparative nonquantitative treatment limit (NQTL) analyses to the Secretary of the Treasury,

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[6] Substance Abuse and Mental Health Services Administration. (2021). National Survey of Substance Abuse Treatment Services (N-SSATS): Accessed June 20, 2023.
[7] Barry, Colleen L., Haiden A. Huskamp, and Howard H. Goldman. "A Political History of Federal Mental Health and Addiction Insurance Parity." Millbank Quarterly, Vol. 88 (2010). Accessed Sept. 4, 2022.
[8] United States Department of Labor. Fact Sheet: The Mental Health Parity Act. Accessed Aug. 8, 2022.
[9] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Pub. L. No. 110-343, 122 Stat. 3881 (2008). Accessed June 3, 2023.
[10] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010). Accessed June 3, 2023.

the Secretary of Labor, and the Secretary of Health and Human Services. The first report was issued in 2022 and found that none of the NQTL analyses submitted contained sufficient information upon initial receipt.[11] Some insurers are working actively to make changes while working through corrective action plans with the federal agencies.[12]

Oregon legislation

Oregon enacted behavioral health parity laws beginning in 1975, and the statute has undergone numerous changes since first enacted. The state's behavioral health parity laws had not been significantly amended since 2005, when the existing mandate was extended to parity coverage of chemical dependency, including alcoholism, and mental or nervous conditions. Oregon has both a mandate for coverage and a parity requirement, while MHPAEA has only a parity requirement.[13] The department issued a bulletin in 2014, providing guidance to insurers about the expectations for insurers in implementing state and federal behavioral health mandates.[14]

In 2021, the Oregon Legislature codified the parity requirements in ORS 743A.168, which provided clarity on the services covered by behavioral health parity and specifies requirements for the use of nonquantitative treatment limits.[15] The bill requires each insurer offering an individual or group health benefit plan that provides behavioral health benefits to:

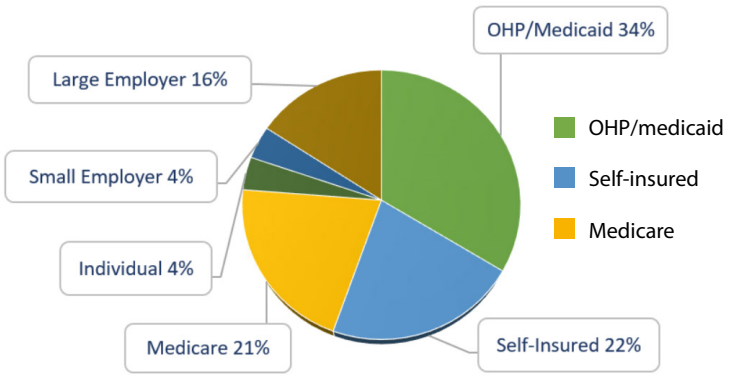
- Annually analyze NQTLs for behavioral health benefits.
- Report to DCBS on NQTLs for behavioral health and substance use disorder, and applicable medical or surgical benefits.

The bill also required DCBS to report to the interim committees of the Legislature related to behavioral health by Sept. 15 of each year, comparing insurers' coverage of behavioral health treatment and services, and substance use disorder treatment and services, to insurers' coverage of medical and surgical treatments or services.

Insurance market and benefits in Oregon

Specific insurance plans are regulated by different agencies with regard to behavioral health parity. This report focuses on the commercial health insurance market, which DCBS regulates. As of March 2023, approximately 1.04 million people were enrolled in Oregon commercial health insurance plans regulated by DCBS, which represents about 23 percent of the state's population. The commercial health insurance market includes fully insured large employer group plans, fully insured small employer group plans, and individual health benefit plans. The figure below displays Oregon health insurance enrollment by market and payer type.

Figure 2: Oregon health insurance enrollment by market and payer type



[11] Department of Labor, Department of Health and Human Services, and Department of the Treasury. "2022 MHPAEA Report to Congress." Accessed Sept. 4, 2022.
[12] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182 (2020). Accessed Aug. 10. 2023.
[13] Oregon Revised Statutes, Chapter 743A — Health Insurance: Reimbursement of Claims, Section 743A.168 — Mental or nervous conditions; chemical dependency, including alcoholism; expenses.
[14] Division of Financial Regulation. Bulletin INS 2014-1.
[15] HB 3046, 2021 Regular Session (OR 2021)

Findings – nonquantitative treatment limitations (NQTL)

Overview of NQTLs

A NQTL is a limit on the amount, duration, or scope of behavioral health or substance use disorder benefits that is not quantified by specific numbers of visits, days, or units of service. NQTLs may be used to manage the costs of these benefits, but they must comply with criteria that do not unfairly target or discriminate against individuals with mental health or substance use disorders. Per the regulations under ORS 743A.168 and the federal MHPEA,[16] a plan is prohibited from imposing an NQTL on behavioral health or substance use disorder benefits unless the methodologies, guidelines, and evidence-based criteria for these benefits are both equivalent to, and not more stringent than, those applied to medical benefits within the same classification.[17] Examples of common NQTLs include:

1. **Medical management standards:** Limitations or exclusions based on medical necessity, appropriateness, or whether the treatment is considered experimental.
2. **Formulary design for prescription drugs:** Tiers or restrictions on medications, potentially affecting access to behavioral health/substance use disorder treatments.
3. **Provider admission standards:** Specific requirements related to reimbursement rates, credentials, or other factors that may restrict the network of providers, influencing the availability of behavioral health services within the network.
4. **Usual, customary, and reasonable charge determinations:** Methods used by insurers to limit what they will pay for a specific service, possibly limiting access to certain providers or treatments.
5. **Coverage restrictions based on location, facility type, or provider specialty:** limitations on benefits according to geographical location, type of facility, or the specialty of the health care provider.

Evidentiary standards

Evidentiary standards refer to the criteria and procedures that insurers must follow to substantiate their policy decisions, such as benefit limitations or exclusions. These standards may rely on medical evidence, expert opinions, or other relevant information. Under HB 3061, insurers are mandated to report the evidentiary standards used for the NQTL factors and all sources used in the design or application of NQTLs for both behavioral health and medical-surgical benefits.

[16] U.S. Department of Labor, Employee Benefits Security Administration. "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program." Accessed Aug. 8, 2023.
[17] Ibid.

Key observations for 2022 include:

1) Methods and analysis:

- Generally, insurers rely on a mixture of internal claims database analysis, review of Medicare rates, and adherence to nationally recognized evidence-based guidelines.
- Typical sources encompass Centers for Medicare & Medicaid Services (CMS), National Coverage Determinations "(NCDs)", Local Coverage Determinations "(LCDs)", American Society of Addiction Medicine (ASAM) criteria, and the Level of Care Utilization System "(LOCUS)", among others.
- Some insurers employ professional judgment committees to assess evidence and align policies with clinical practice guidelines.

2) Medical-surgical standards:

- For medical-surgical standards, insurers predominantly use nationally recognized criteria such as Milliman Care Guidelines and CMS guidelines to ascertain the appropriateness, safety, and medical necessity of services.
- Several insurers consider the cost of treatment; potential for fraud, waste, or abuse; and return on investment when subjecting treatments to prior authorization.

3) Behavioral health standards:

- Behavioral health standards tend to integrate specific sources such as ASAM criteria, the Diagnostic and Statistical Manual of Mental Health Disorders 5 (DSM-5), and specialized committees.
- There is a marked focus on addiction and behavioral health criteria, with guidelines being evaluated for appropriateness in specialized utilization management committees.

4) General observations:

- Some insurers adopt a more cohesive approach, employing the same guidelines and sources for both medical-surgical services and behavioral health services, such as the Agency for Healthcare Research and Quality "(AHRQ)" and the U.S. Food and Drug Administration "(FDA)", among others.
- Some insurers include an extensive list of evidentiary sources without clarifying their usage, while others do not recognize that commonly used standards are widely available. Many insurers are deficient in data showing comparative analyses between written policies and operational policies. Statements of parity are often made without detailing the specific comparisons or data used to make such determinations.

The above observations reveal a complex landscape in the application and understanding of evidentiary standards across different insurers. The general trends suggest a need for greater clarity, consistency, and transparency in how standards are used and applied across behavioral health and medical-surgical contexts.

Comparative analysis of behavioral health and medical-surgical benefits

The comparative analysis aims to assure parity between the processes, strategies, evidentiary standards, and other factors applied to behavioral health and medical-surgical benefits. The 2022 findings include:

1) NQTL application:

- All insurers stated in their reports that NQTLs are applied equally to behavioral health and medical-surgical benefits. However, most failed to furnish comprehensive evidence to support these claims.
- Insurers report NQTL data with wide variations, from detailed narratives with supporting data to vague generalizations without evidence.
- Insurers employ different methods for categorizing and reporting NQTLs, which creates challenges for data classification and hampers the consistency of reporting. For instance, one insurer may categorize an NQTL under a "Utilization Management" heading, while another might list the same type of limitation under "Cost-Management Strategies." This inconsistency makes it difficult to directly compare data across insurers, affecting the reliability and validity of overarching analyses.

2) Transparency issues:

- Most insurers have not adequately disclosed the methods and reasoning behind their application of NQTLs. This lack of transparency hampers a comprehensive understanding of how NQTLs are applied and makes it difficult to assess whether they are being implemented in a manner that meets parity requirements. For example, while some insurers may offer generic statements such as "NQTLs are applied to ensure cost-effectiveness," they often fail to provide specific criteria, benchmarks, or metrics used to make their determinations. The absence of this data restricts a comprehensive evaluation of parity. What would be more helpful are detailed explanations that include:
- The exact criteria used for establishing an NQTL.
- Benchmarks or metrics that signify whether the criteria have been met.
- Case examples to illustrate the application of these criteria in real-world scenarios.
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3) Network adequacy challenges:

- Several insurers have faced difficulties in maintaining a network of providers sufficient in number and specialty to meet the behavioral health needs of their members.

The comparative analysis reveals challenges and inconsistencies among insurers in the application of NQTLs to both behavioral health and medical-surgical benefits. Achieving parity is hindered by issues that include an absence of transparency in methods, inconsistencies in how NQTL data are reported, and shortcomings in the network of providers. Current efforts by the division focus on identifying the full extent of these problems, to develop targeted strategies for direct discussions with the insurers. Continued attentiveness, cooperative efforts, and open communication will be fundamental in addressing these diverse challenges, promoting fair and consistent treatment in both the behavioral health and

medical-surgical sectors.

Challenges with NQTL analysis

Federal challenges

The federal government has faced substantial challenges in regulating NQTLs, as detailed in various reports and guidelines, including the "2022 MHPAEA Report to Congress."[18] Primary issues highlighted include:

- Lack of adequate comparative analysis: Of the 156 comparative analyses initially examined, none were found to be sufficient. These inadequacies include comparisons between behavioral health/substance use disorder benefits and medical-surgical benefits.
- Stringent application of NQTLs to behavioral health: This refers to an overly exacting application of NQTLs to behavioral health services, resulting in difficulties in uniformly implementing the MHPAEA.
- Deficiencies in comparative analyses: Specific shortcomings include failure to identify the benefits, lack of detailed descriptions, insufficient identification of factors, and absence of a comprehensive analysis of stringency.

To address these challenges, several federal agencies, such as the departments of Labor, Health and Human Services, and Treasury, have undertaken these actions:

- Clarifying expectations: The issuance of guidance documents to promote uniform application.
- Collaborating with industry stakeholders: Coordinated efforts to cultivate understanding and compliance.
- Enhancing oversight: An increase in audits and investigations to ensure proper adherence to regulations.[19]
- Investing in education and training: The provision of education, training, and technical assistance to both regulators and insurers to foster consistent and unbiased application of NQTL regulations.
- In addition, the Department of Labor has advocated for congressional action on targeted measures, encompassing the establishment of civil monetary penalties for parity violations, amendments to the Employee Retirement Income Security Act "(ERISA)" to bolster enforcement authority, and the broadening of telehealth and remote care services.

Oregon challenges

The challenges identified at the federal level closely parallel the obstacles encountered in Oregon concerning NQTL analysis. In Oregon, insurers have faced challenges with inconsistent application and varied interpretations of NQTLs, varied interpretations of NQTL's, and insufficient detail in comparative analyses. The alignment between federal and state experiences underscores the necessity for ongoing improvement, transparent guidelines, and collaborative efforts among agencies at both levels. The strategies pursued at the federal level may serve as valuable lessons for Oregon, helping to refine its regulatory approaches regarding NQTLs and promoting greater uniformity and fairness.

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[18] U.S. Department of Labor, Employee Benefits Security Administration, "2022 MHPAEA Report to Congress," accessed August 14, 2023.
[19] Substance Abuse and Mental Health Services Administration, "Roadmap to Behavioral Health: A Guide to Using Mental Health and Substance Use Disorder Services," U.S. Department of Health and Human Services, 2016, accessed Aug. 2, 2023.

Findings – claims, denials, and provider rates

Claims

During the reporting period, the number of claims filed for medical-surgical services surpassed the number of claims filed for behavioral health services, resulting in a ratio of 4.1 medical-surgical claims for every one behavioral health claim. This indicates a higher utilization of medical-surgical services compared to behavioral health services during the reporting period. This ratio represents a slight decrease from the previous year's ratio of 4.38:1, suggesting potential shifts in utilization patterns.

The majority of paid claims for both behavioral health and medical-surgical services were paid to in-network providers. However, when examining the average percentages of claims paid to out-of-network providers, a notable distinction arises. Behavioral health claims exhibited a higher average percentage of claims paid to out-of-network providers at 10.68 percent, whereas medical-surgical claims had an average percentage of 4.03 percent paid to out-of-network providers.

These figures indicate that, on average, a greater portion of claims for behavioral health services were settled with out-of-network providers compared to medical-surgical services. This suggests that people seeking behavioral health services may have encountered challenges accessing in-network providers or chose out-of-network care due to factors such as provider availability or personal preferences. Conversely, a lower average percentage of claims for medical-surgical services were paid to out-of-network providers, indicating a higher likelihood of people accessing care within their network when seeking medical and surgical treatments.

A year-over-year analysis from 2021 to 2022 reveals changes in the percentages of claims paid to in-network and out-of-network providers for both behavioral health and medical-surgical benefits.

In terms of claims paid to in-network providers for behavioral health benefits, the data demonstrates an increase from 83.71 percent in 2021 to 89.33 percent in 2022. This indicates that, on average, a higher proportion of behavioral health claims were settled with in-network providers in 2022 compared to the previous year.

Figure 3: Percentage of claims by type of service and provider network status

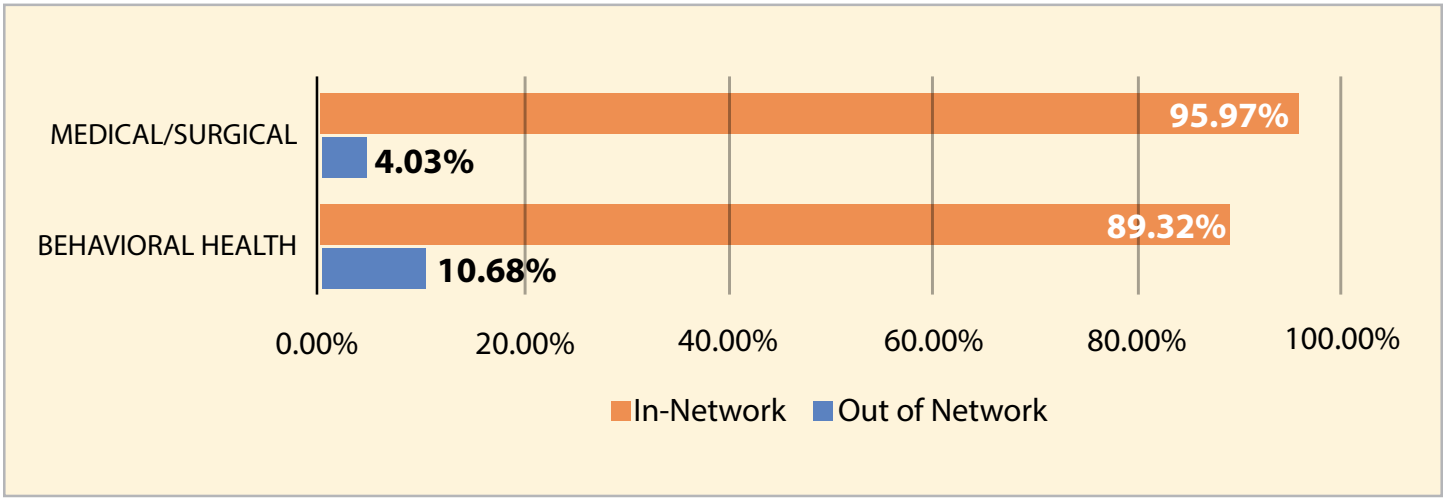
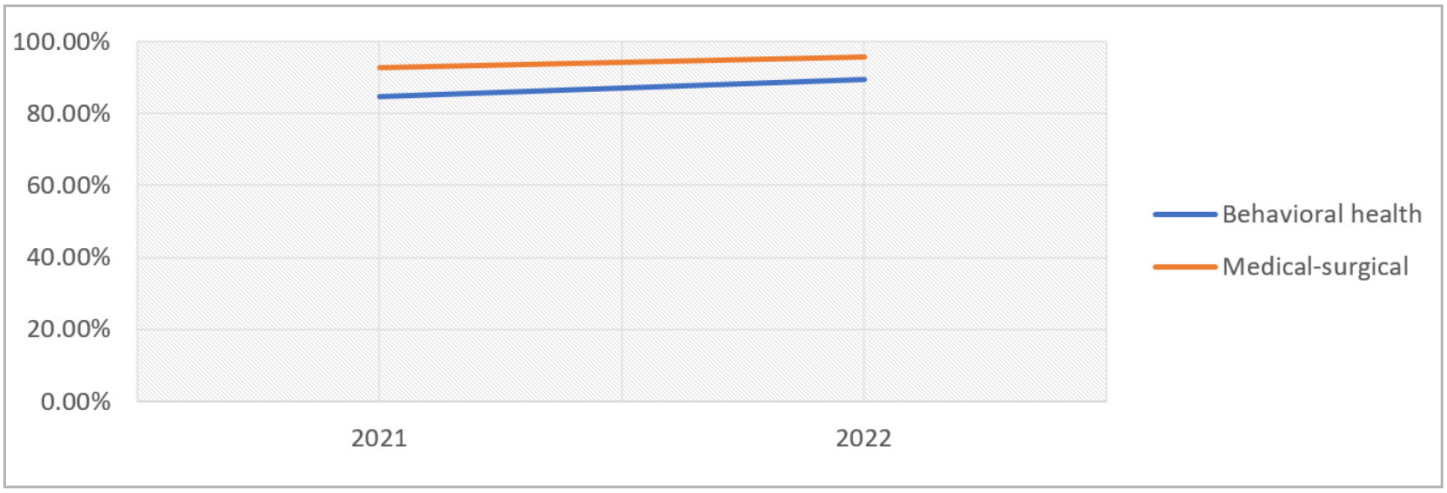


Figure 4: Percentage of claims paid to in-network providers



For medical-surgical benefits, the data indicate an upward trend in claims paid to in-network providers. Specifically, in 2021, approximately 92.82 percent of medical-surgical claims were paid to in-network providers, a figure that rose to 95.59 percent in 2022. While this suggests improved access to in-network medical-surgical care during the reporting period, it is important to interpret these data cautiously. This increase in in-network claims may imply better access, but it is not conclusive evidence of such, as it is also possible that some individuals may not be accessing care at all. It should be noted that the total number of medical-surgical claims increased from 2021 to 2022, indicating that overall health care utilization has risen, not diminished. The rise of in-network claims may also be influenced by the ongoing effects of the COVID-19 pandemic, which altered health-care seeking behaviors and possibly contributed to the increased utilization.

Telehealth

Insurers are required to report on telehealth claims, including the total number of claims for behavioral health and medical-surgical services, any differences in the median maximum allowable reimbursement rate for care provided by a behavioral health provider or a medical-surgical provider, and other relevant information.

During the reporting period, telehealth services continued to play a significant role in health care delivery. Across all insurers, behavioral health benefits consistently exhibited higher rates of telehealth utilization, while medical-surgical benefits had comparatively lower usage. This suggests that telehealth is more commonly used in the delivery of behavioral health care than in medical-surgical services.

Figure 5: Percentage of claims paid to out-of-network providers

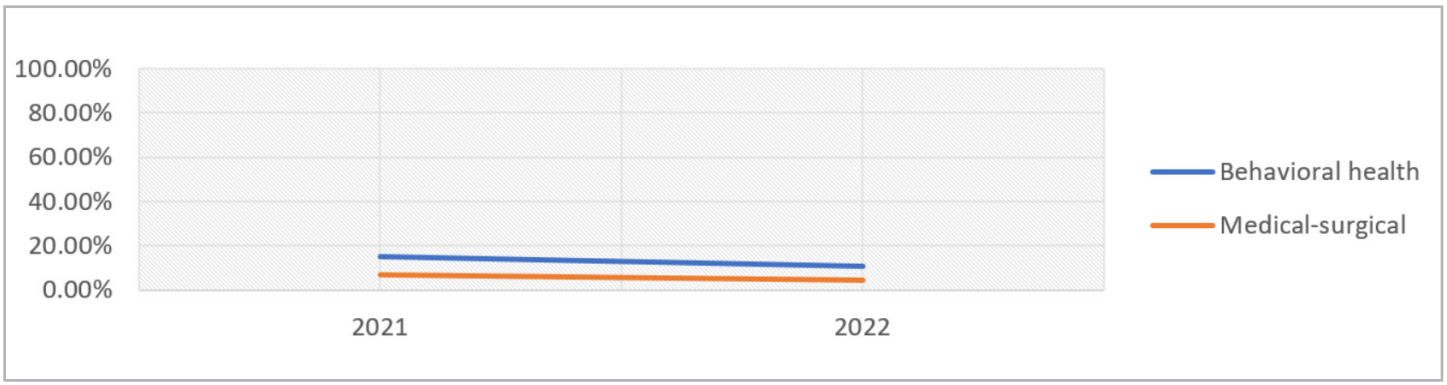


Figure 6: Summary data on aggregate claims and telehealth claims for all insurers

	Total claims	Total telehealth claims	Total percentage
Behavioral health	1,511,043	965,918	72.56%
Medical-surgical	6,196,004	365,301	27.44%

The utilization of telehealth services for behavioral health saw a slight increase with 965,918 telehealth claims in 2022 compared to 925,221 in 2021. However, when examining telehealth claims for behavioral health services at the individual insurer level, the data exhibit significant variation. Some insurers reported a decrease in telehealth claims for behavioral health benefits in 2022 compared to 2021, while others experienced a slight increase in telehealth utilization. Despite these variations, telehealth remained a significant component of accessing behavioral health services overall.

Figure 7: Summary data on aggregate claims and telehealth claims for all insurers

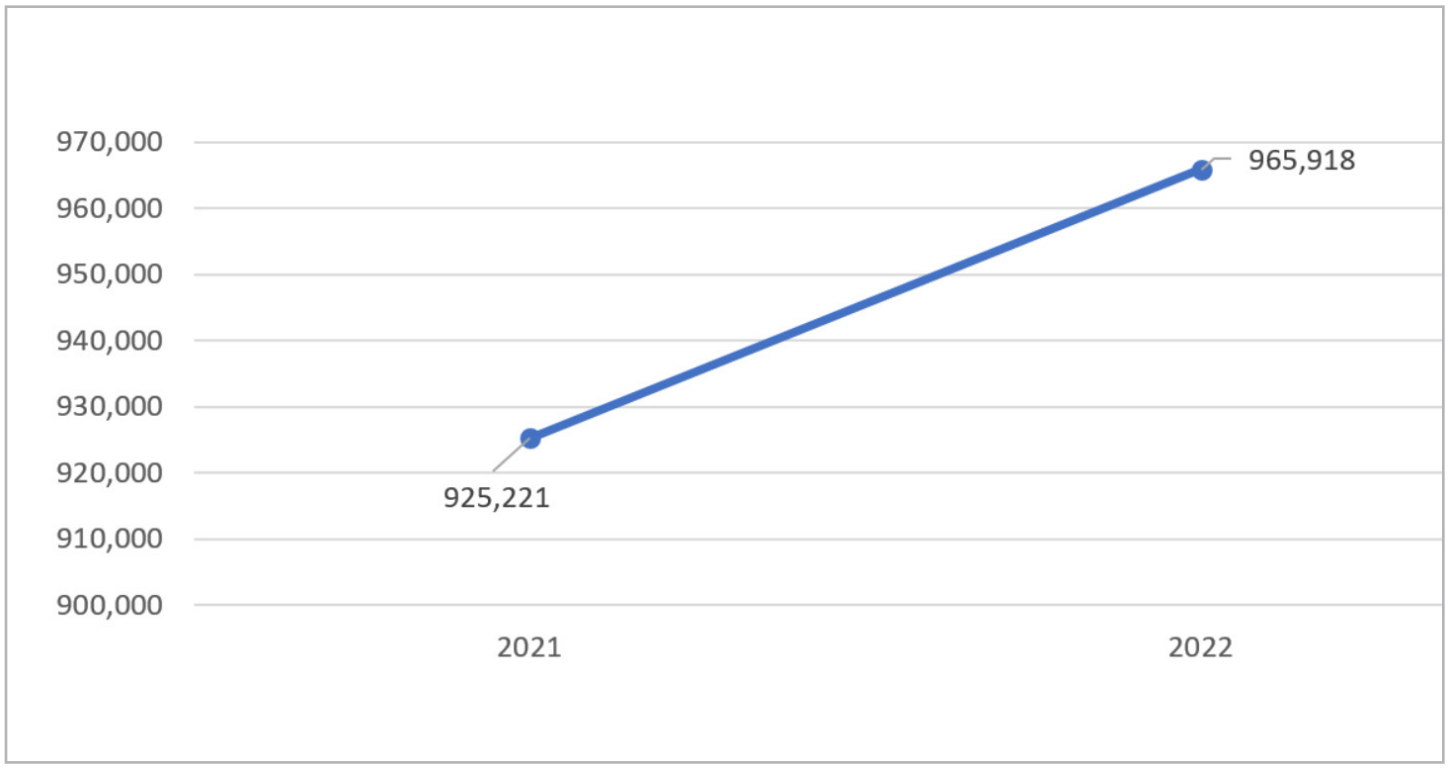
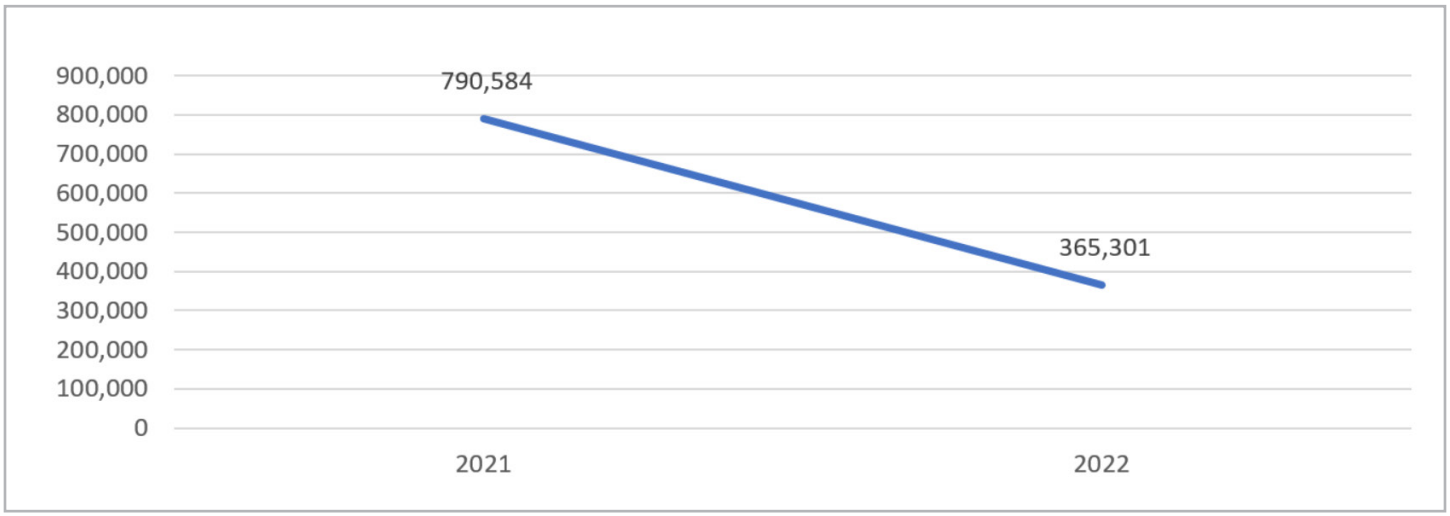


Figure 8: Year-to-year comparison: medical/surgical telehealth claims



In contrast, medical-surgical services witnessed a significant decline in the number of telehealth claims, with 365,301 claims in 2022 compared to 790,584 claims in 2021. This decline suggests a shift in utilization patterns, potentially influenced by the relaxation of pandemic-related restrictions and a return to more in-person medical visits for nonurgent care.

Denials

In 2022, 1,511,043 claims for behavioral health benefits were submitted. Of these claims, 99,630 were either partially or fully denied, yielding an average denial rate of 6.59 percent. It is essential to note that a denial could refer to a specific service or line item within an individual claim, rather than implying rejection of the entire claim. During the subsequent appeal process, the outcomes demonstrated variability across different insurers, with denials being upheld, overturned, or remaining in a pending status for initial decisions.

Conversely, medical/surgical benefits in 2022 saw 6,196,004 claims submitted, with 776,343 claims denied, leading to an average denial rate of 12.53 percent. Similar to behavioral health benefits, the appeal process for medical/surgical claims exhibited differences in appeal outcomes among insurers.

Comparing these data to 2021, there are noteworthy shifts in denial rates. In 2021, the average denial rates were 8.76 percent for behavioral health benefits and 8.77 percent for medical/surgical benefits, indicating a relatively balanced denial rate between the two benefit types. However, in 2022, a more distinct discrepancy emerged, with a lower average denial rate of 6.59 percent for behavioral health benefits and a higher rate of 12.53 percent for medical-surgical benefits.

This indicates a potential change in claims processing practices or criteria for medical-surgical benefits in 2022, leading to a higher denial rate compared to the previous year. Also, the wide range of claims to denial ratios across insurers highlights the variability in claims processing practices, which warrants further investigation to understand the reasons behind these discrepancies.

Figure 9: Ratio of claims to denials for behavioral health and medical-surgical claims for years 2021 and 2022.

		2021	2022
Behavioral Health Claims	Total Claims Submitted	1,262,269	1,511,043
	Total Claims Denied	110,519	99,630
	Average Denial Rate (%)	8.76%	6.59%
Medical/Surgical Claims	Total Claims Submitted	5,524,081	6,196,004
	Total Claims Denied	484,535	776,343
	Average Denial Rate (%)	8.77%	12.53%

Provider rates

Insurers reported information on provider rates as the median maximum allowable rate for incurred claims during 2023. In future years, these reports may include the contracted provider rates and coverage of International Statistical Classification of Diseases and Related Health Problems (ICD) codes to more comprehensively understand parity in provider rates. The applicable Oregon Administrative Rule defines the median maximum allowable rate as "The applicable Oregon Administrative Rule defines the median maximum allowable rate as "the median of all maximum allowable reimbursement rates, minus incentive payments."[20] These rates were reported in several forms by current procedural terminology (CPT) codes listed on the division's website.[21] Provider rates were submitted by CPT code and provider type for both in network and out of network, and geographic region.

In network

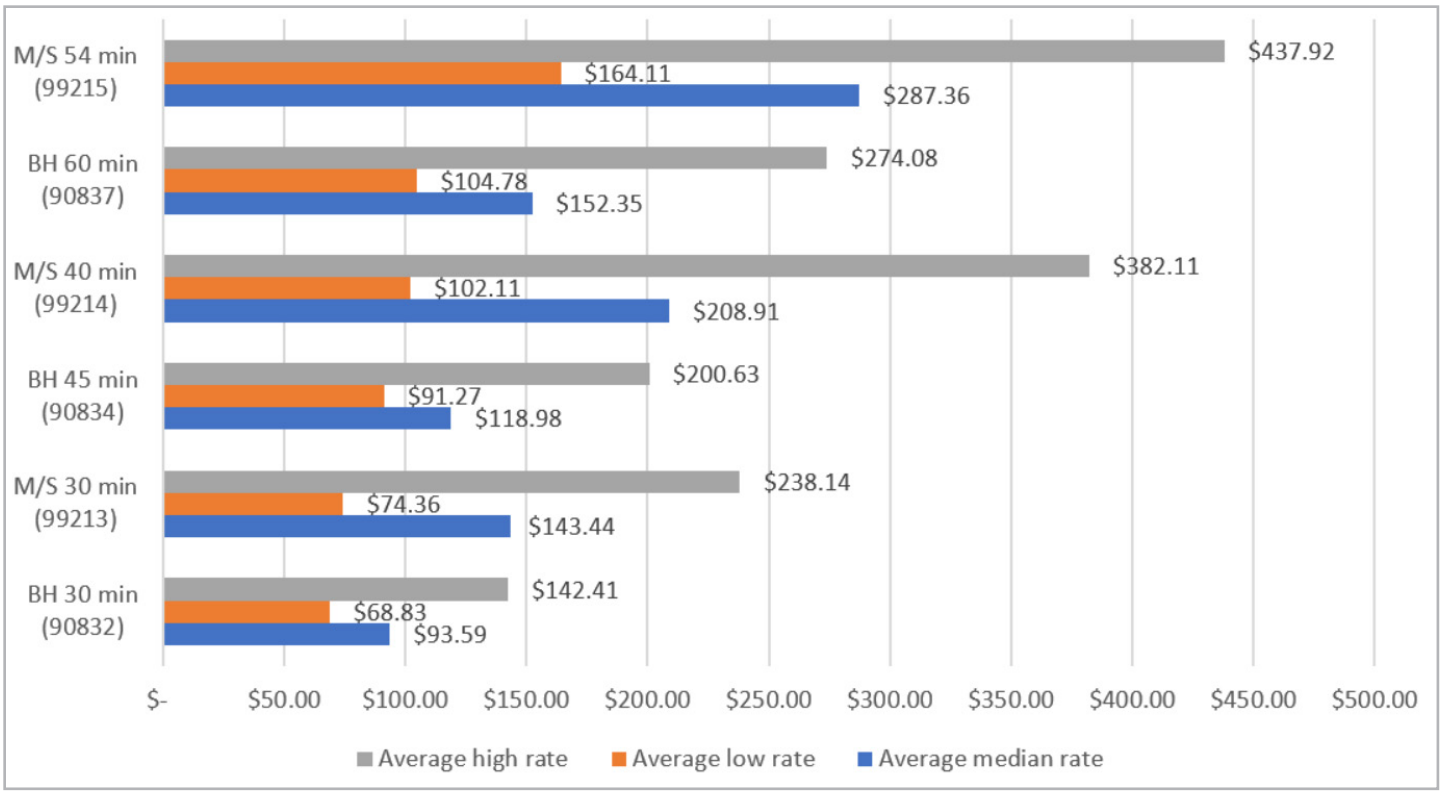
Rates were reported by each company for CPT codes related to office visits and other common procedures that occur within both behavioral health services and medical-surgical services. The U.S. Department of Labor provides a framework for insurers to use to analyze provider reimbursement rates to determine if more steps are warranted to examine reimbursement methodology. It is advised that the insurer take steps to evaluate reimbursement rates if the analysis indicates that the rate is lower for behavioral health providers as compared to medical-surgical providers or an external benchmark, such as Medicare rates.[22] The framework provides reference CPT codes for conducting this comparative analysis using CPT codes related to office visits for both behavioral and medical-surgical providers.

Figure 10 displays the average median, low, and high in-network reimbursement rates for specified related office visit CPT codes for both behavioral health and medical-surgical services. These rates are averaged between all companies to compare the average reimbursement rates at a market level.

The difference between the average median reimbursement rate across all six CPT codes in Figure 10 for a psychotherapy visit with a

[20] OAR 836-053-1425(4).
[21] Oregon Division of Financial Regulation. "HB 3046 Annual Reporting CPT Code List". Accessed, August 2023.
[22] Department of Labor. "Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)." Accessed, August 2023.

Figure 10: Average in-network reimbursement rates for behavioral health (BH) and medical-surgical (M/S) office visit by CPT code.



Data collected by DFR in 2023

behavioral health provider versus an office visit with a medical-surgical provider is approximately $91.60. In guidance on provider reimbursement, differences in rates indicate a need for further evaluation of reimbursement methodology.

Figure 11: Average median rate of reimbursement to in-network behavioral health providers using 30-minute medical-surgical office visit (CPT code 99213)

Figures 11 and 12 provide a visualization of year-to-year reimbursement rate changes for in-network behavioral health and medical-surgical providers. CPT code 99213 (30-minute medical-surgical office visit) was used for comparison. Rates slightly increased for both behavioral health and medical-surgical providers from 2021 to 2022.

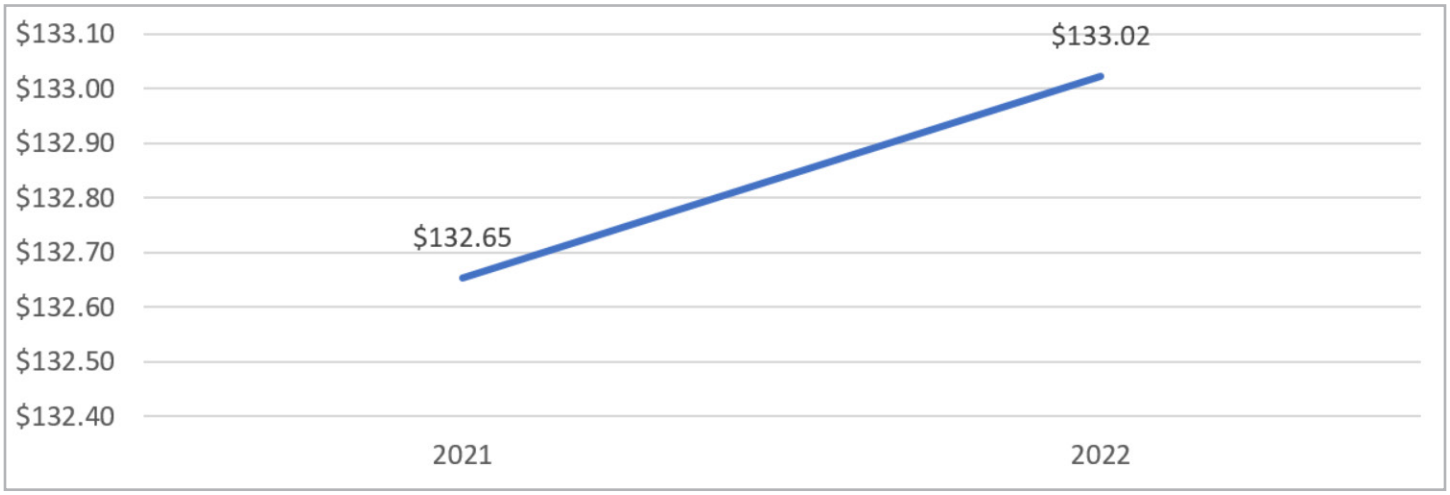
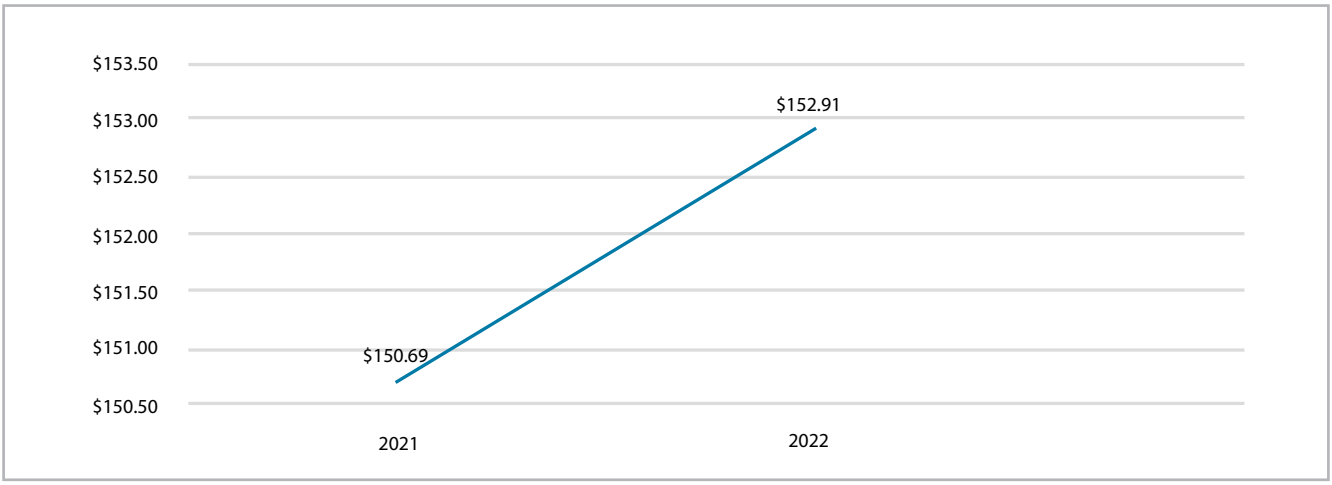


Figure 12: Average median rate of reimbursement to in-network medical-surgical providers using 30-minute medical-surgical office visit (CPT code 99213)



Data collected by DFR in 2023.

Average median reimbursement rates were reported by provider type as another way to analyze parity. The table below displays these reimbursement rates for several different types of providers. Some provider types use CPT codes for both behavioral health psychotherapy office visits and medical-surgical office visits.

Figure 13: Average of median in-network reimbursement rates for behavioral health and medical-surgical office visit by provider type

Data collected by DFR in 2023.

	Behavioral health – psychotherapy			Medical-surgical office visit		
Provider Type	**30 min (90832)**	**45 min (90834)**	**60 min (90837)**	**30 min (99213)**	**40 min (99214)**	**54 min (99215)**
Clinical social Worker	$77.54	$102.82	$124.65	$136.54	$199.05	$281.73
Marriage and family therapist	$72.52	$93.04	$124.34	$136.54	$184.85	$246.60
Nurse practitioner				$148.38	$216.84	$290.35
Professional counselor	$65.77	$92.38	$124.81	$151.36	$177.89	$245.98
Physician assistants	--	--	--	$154.20	$224.46	$306.54
Physicians	--	--	--	$149.84	$223.29	$298.24
Nurse practitioner - psychiatric mental health	$107.21	$146.14	$195.77	$126.68	$181.31	$247.43
Psychologist	$127.49	$166.65	$206.55	$131.18	$203.75	$286.55
Psychiatrists	$121.88	$128.78	$159.40	$140.03	$239.00	$334.00
Reg. interns	$76.31	$123.33	$143.66	$185.41	$238.68	$303.75
Average rate	$92.68	$121.88	$154.17	$146.01	$208.91	$284.12

When comparing provider types, there are differences within the same CPT code where reimbursement rates are more comparable to other provider types. Some significant differences for certain providers between the CPT codes for behavioral health and medical-surgical still exist. A professional counselor, clinical social worker, and marriage and family therapist are reimbursed 43 percent to 53 percent more for a 30-minute medical-surgical office visit versus a 30-minute behavioral health office visit.

For all provider types, the median reimbursement rates for medical-surgical office visit CPT codes are higher than the comparable behavioral health office visit CPT codes. Again, it is difficult to make definitive conclusions this year about reimbursement rate methodologies based on the data alone; however, insurer narrative reports identified factors that affect provider reimbursement rates:

- Rates for a given CPT code may vary based on executed contracts with the provider and according to the provider type.
- Geographic market (market rate and payment type for provider type and/or specialty)
- Type of provider (i.e., hospital, clinic, and practitioner) and/or specialty
- Training, experience, and licensure of provider
- Supply and demand conditions such as:
  - Supply of provider type and/or specialty
  - Provider's market position
  - The number of providers of a particular provider type in the geographic market
  - Network need and/or demand for provider type and/or specialty (e.g., languages spoken, ethnicity)
  - Volume of referrals the plan would intend to send to the provider and the capacity of the provider to accept referrals
  - Any other unique market conditions
- Treatment protocols and type of service defined within each CPT code
- Market benchmarks such as:
  - Existing contract rates
  - CMS Medicare reimbursement rates
  - Consumer Price Index
  - Claims data

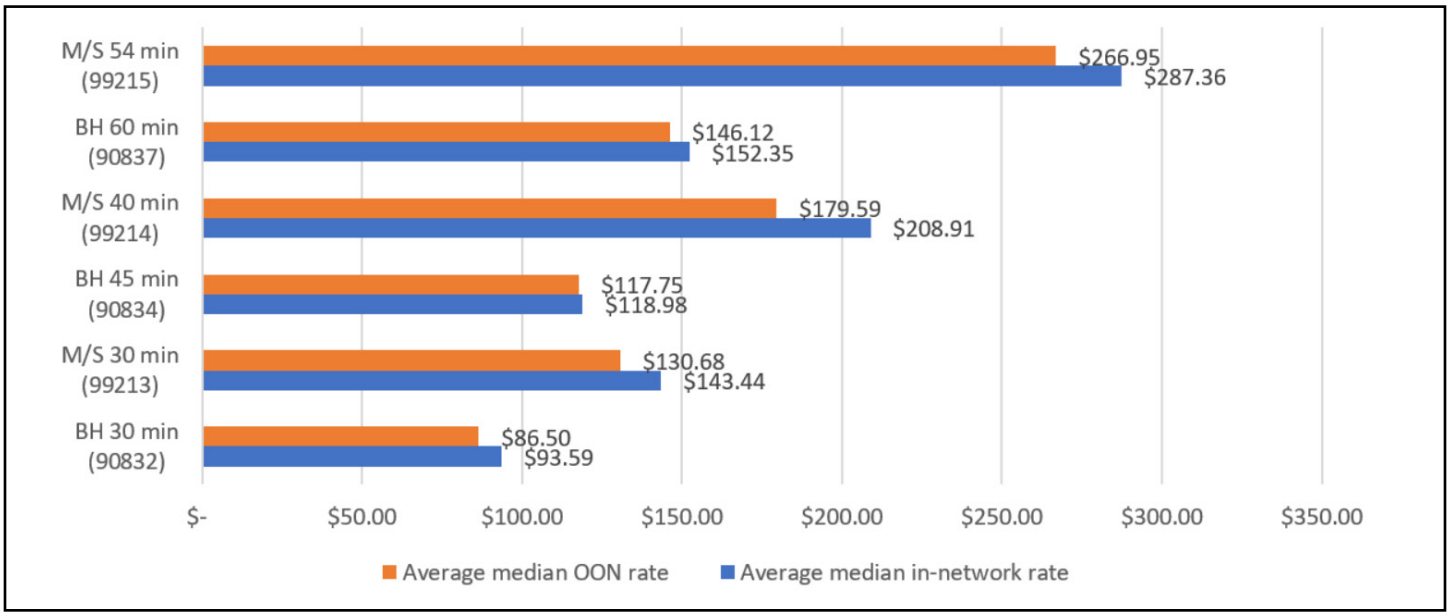
Insurer narrative reports included comments that parity should be measured by comparing rates for CPT codes that can be used by both behavioral health and medical-surgical providers based on the insurer's preferred rate schedule presented to providers when the insurer is seeking to contract with the provider. The division has used a comparative analysis methodology of using common CPT office visit codes that can be used by both behavioral health and medical-surgical providers. We are open to suggestions from insurers and other stakeholder if more common codes could be considered for comparison.

The division recognizes that further evaluation is needed to understand how reimbursement rate factors result in different reimbursement rates by provider type for comparable CPT codes.

Out of network

Insurers reported on the average of median out-of-network reimbursement rates for the same CPT codes and provider types. The average of median out-of-network reimbursement rates reported for comparable behavioral health and medical-surgical office visit CPT codes were reported to be lower than in-network rates. The CPT codes 90832 and 90837 relating to 30-minute and 60-minute behavioral health psychotherapy visits, respectively, had a $6.66 average higher median reimbursement rate for in-network compared to out-of-network reimbursement rates.

Figure 14: Comparison of average of median in-network and out-of-network reimbursement rates for behavioral health and medical-surgical office visit by CPT.



Data collected by DFR in 2023.

Out-of-network reimbursement rates were also reported by provider type. Most out-of-network reimbursement rates were lower than the in-network reimbursement rates, which follows provider feedback. The table below displays the average median in-network and out-of-network reimbursement rates by provider type for 30-minute behavioral health psychotherapy versus medical-surgical office visits.

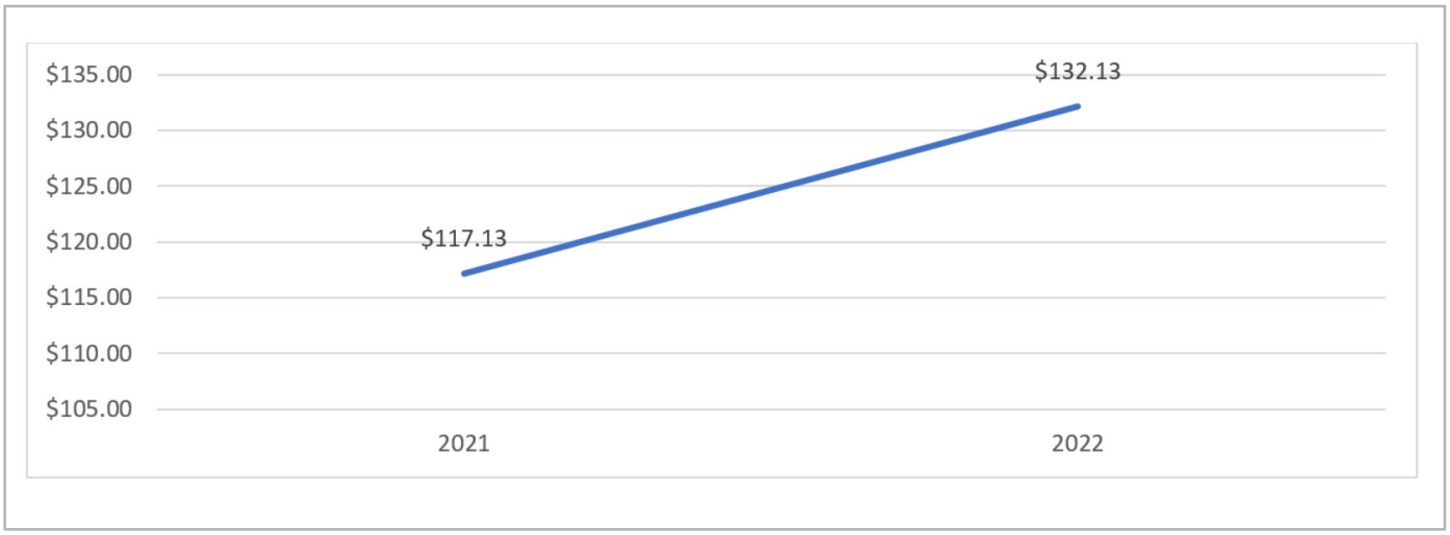
Figure 15 (below) illustrates that certain provider types are reimbursed at a higher rate for out of network compared to in network. Most of the provider types are reimbursed at a higher rate for medical-surgical CPT code compared to the similar behavioral health CPT code.

Figure 15: Average of median in-network and out-of-network reimbursement rates for 30-minute behavioral health and medical-surgical office visit by provider type.

	BH 30 min (90832)		M/S 30 min (99213)	
Provider Type	**In-network**	**Out-of-Network**	**In-network**	**Out-of-Network**
Clinical social worker	$77.54	$71.19	$136.54	$138.03
Marriage and family therapist	$72.52	$68.39	$136.54	$136.54
Nurse practitioner	--	--	$148.38	$128.51
Professional counselor	$65.77	$70.77	$151.36	$134.77
Physician assistants	--	--	$154.20	$124.36
Physicians	--	--	$149.84	$127.63
Nurse practitioner - psychiatric mental health	$107.21	$101.77	$126.68	$131.86
Psychologist	$127.49	$120.10	$131.18	$122.21
Psychiatrists	$121.88	$117.87	$140.03	$148.06
Reg. interns	$76.31	$83.16	$185.41	$165.00

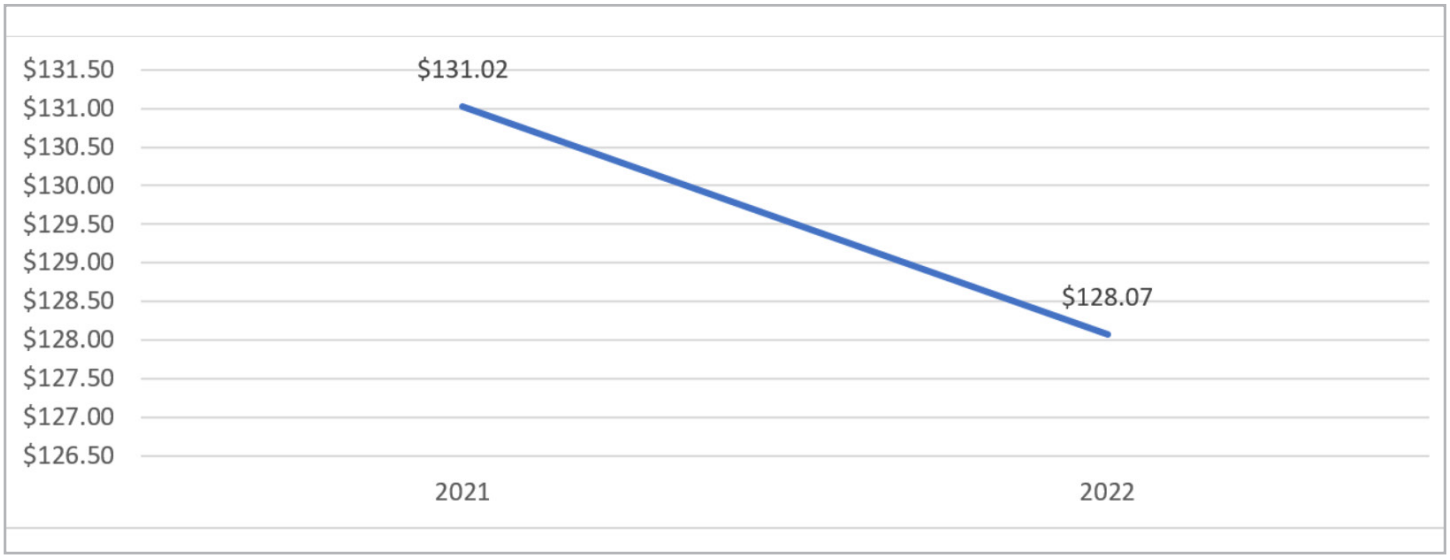
Figures 16 and 17 (below) provide a visualization of year-to-year reimbursement rate changes for out-of-network behavioral health and medical-surgical providers. CPT code 99213 (30-minute M/S office visit) was used for comparison. Rates increased for behavioral health providers compared to medical-surgical provider rates that decreased from 2021 to 2022.

Figure 16: Average median out-of-network reimbursement rate to behavioral health providers using 30-minute medical-surgical office visit (CPT code 99213)



Data collected by DFR in 2023.

Figure 17: Average median rate of reimbursement to out-of-network medical-surgical providers using 30-minute medical-surgical office visit (CPT code 99213)



Data collected by DFR in 2023.

Geographic rate

Reimbursement rates differ depending not only on the type of provider, but also on the geographic area where the services were received. Geographic regions were reported consistent with Oregon's seven geographic rating areas for health benefit plans.[23] The table below displays the average of median reimbursement rates for 30-minute psychotherapy or medical-surgical office visits by geographic region compared to the percent of the Medicare reimbursement rate by geographic region. The comparable behavioral health and medical-surgical CPT codes are more than 100 percent of the Medicare reimbursement rate for each geographic region.

Figure 18: Average of median in-network reimbursement rates for 30-minute behavioral health and medical-surgical office visit by geographic region.

	BH 30 min (90832)		M/S 30 min (99203)	
Geographic region	**Reimbursement rate**	**% of Medicare Rate**	**Reimbursement rate**	**% of Medicare Rate**
1. Portland metro	$91.55	130.53%	$143.51	162.92%
2. Mid-Willamette	$90.85	137.32%	$151.68	179.01%
3. Marion-Polk	$81.16	125.48%	$147.30	177.94%
4. Central-southern Cascades	$84.61	120.44%	$133.20	153.86%
5. North and south coast	$78.93	121.56%	$140.67	169.13%
6. Central-eastern	$75.70	112.59%	$129.39	155.69%
7. Southern Willamette	$91.28	134.15%	$152.72	181.43%

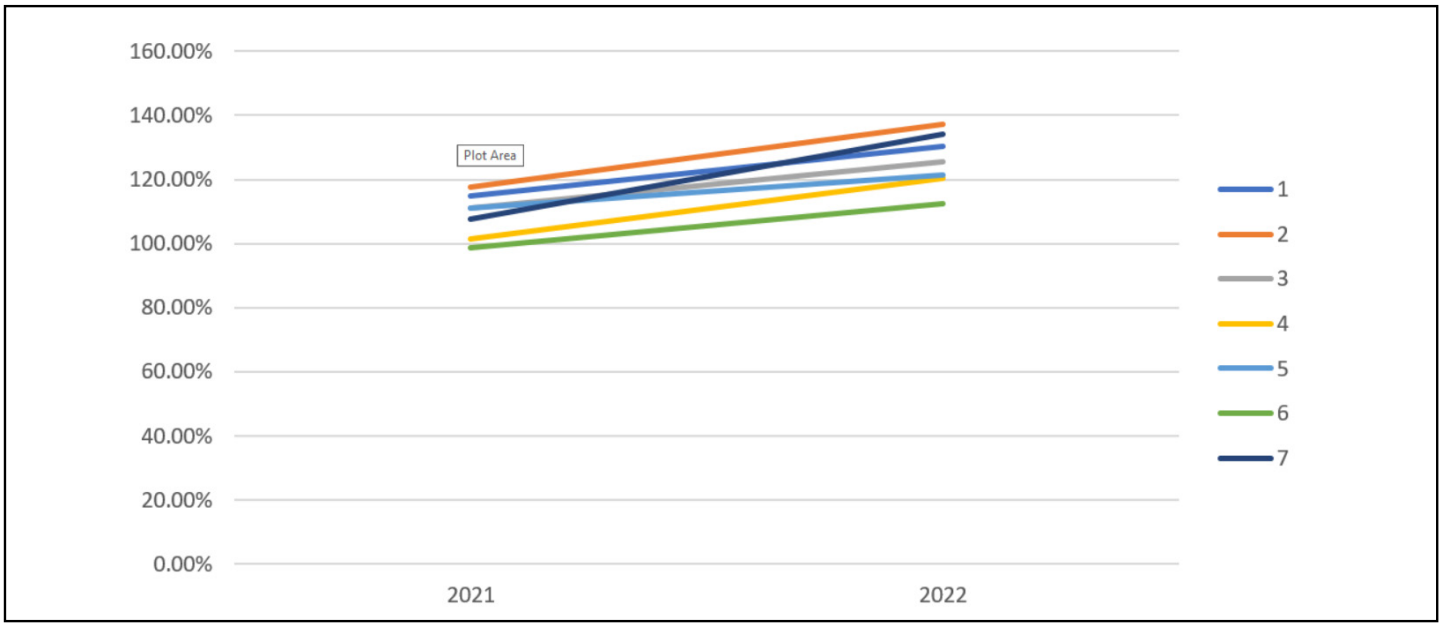
Data collected by DFR in 2023.

[23] Oregon Division of Financial Regulation. "Oregon Geographic Rating Areas". Accessed, August 2023.

Figures 19 and 20 (below) provide a 2020 to 2021 rate comparison by geographic region compared to the percent of the Medicare rate. CPT code 90832 (30-minute behavioral health office visit) was used for the behavioral health providers year-to-year comparison. CPT code 99213 (30-minute medical-surgical office visit) was used for the medical-surgical providers year-to-year comparison.

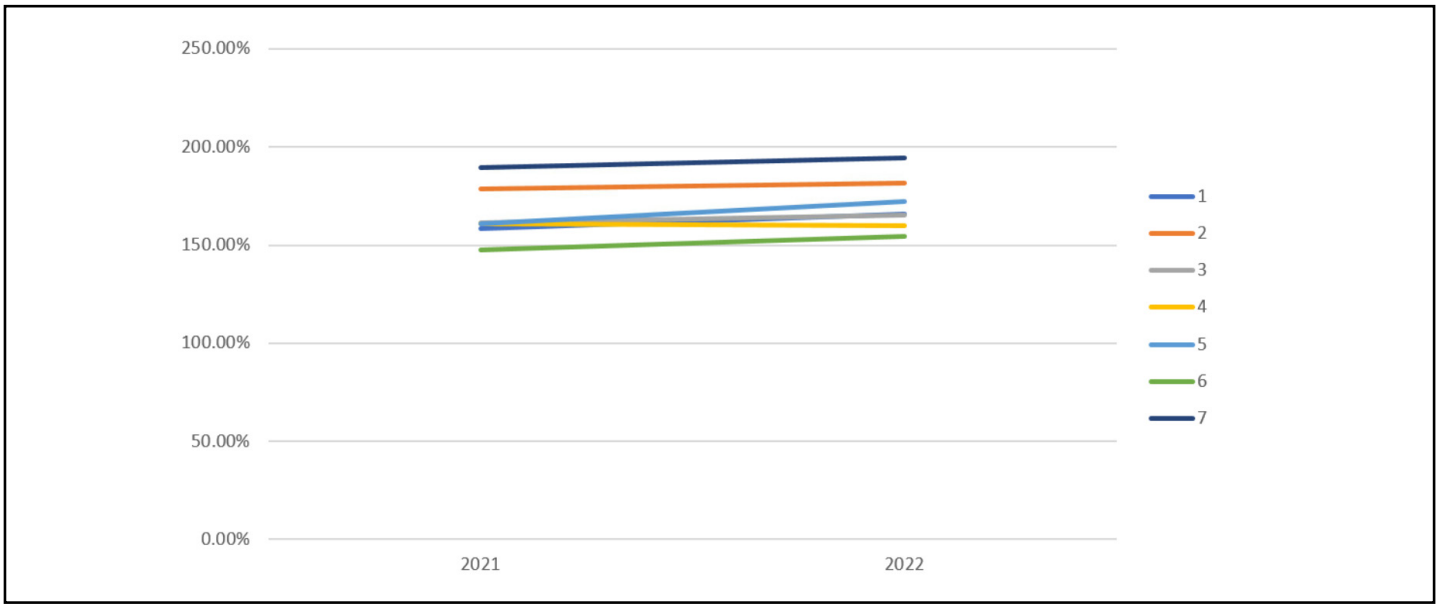
Behavioral health provider geographic region rates compared to the percent of the Medicare rate for CPT code 90832 increased from 2020 to 2021. Medical-surgical provider geographic region rates compared to the percent of the Medicare rate for CPT code 99213 slightly increased or remained level.

Figure 19: Behavioral health reimbursement rate compared to the percent of the Medicare rate by geographical region using 30-minute behavioral health office visit (CPT code 90832)



Data collected by DFR in 2023.

Figure 20: Medical-surgical reimbursement rate compared to the percent of the Medicare rate by geographical region using 30-minute behavioral health office visit (CPT code 90832)



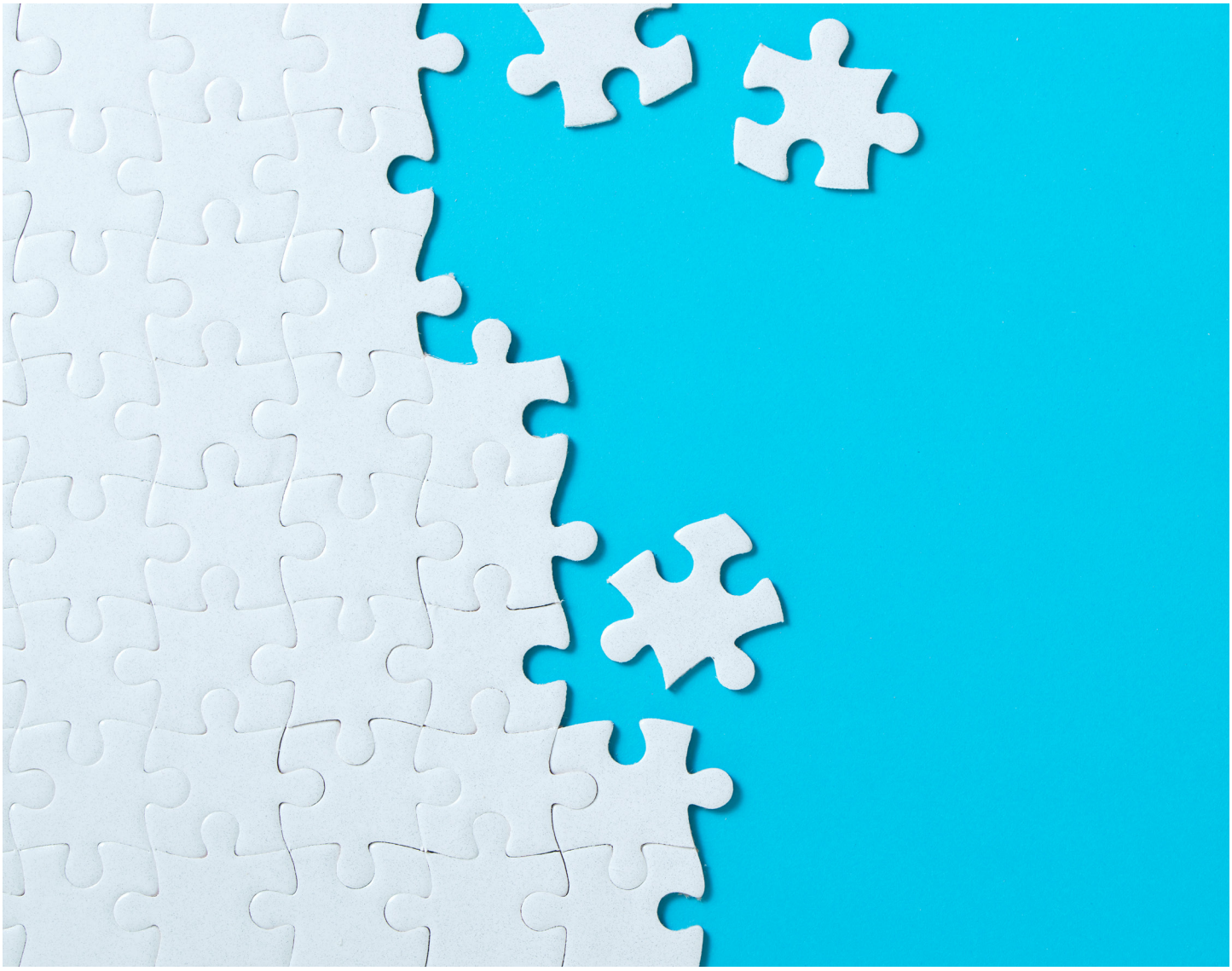
Data collected by DFR in 2023.

Conclusion

The findings in this annual report under House Bill 3046 (2021) help inform an assessment of Oregon's ongoing efforts to achieve behavioral health parity in the commercial health insurance market. The journey toward equitable access to behavioral health and substance use disorder treatment services has demonstrated notable progress in certain areas, but has also illuminated the persistence of significant challenges.

The division will continue to work closely with other state insurance regulators, federal agencies, national nonprofits and other stakeholders to continuously improve evaluating commercial health insurance compliance with mental health parity regulations.

DFR is considering contracting with an experienced and objective behavioral health parity consultant to review the division's current parity evaluation process, including its 2021 and 2022 NQTL and quantitative data reports, to provide recommendations for process improvement.



Appendix

Appendix A: Reporting Form for NQTL Analysis

House Bill 3046 Reporting: Nonquantitative Treatment Limitation (NQTL) Reporting submission form

The reporting submission form below is required to be submitted as part of an insurer reporting on NQTLs in compliance with Oregon Laws 2021, ch. 629. This form designed by Tim Clement of the American Psychiatric Association and vetted with the HB 3046 rulemaking advisory committee.

NQTLs are limitations on the scope or duration of benefits for treatment. These can include but are not limited to:

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

More information on NQTLs and examples can be found in 45 CFR 146.136(c)(4)(ii).

Final reports are due by April 1, 2022, along with the data reporting template (Excel workbook).

Send reports to DFR.DataTeam@dcbs.oregon.gov and Tashia.Sizemore@dcbs.oregon.gov.

[Insert NQTL]

This NQTL reporting submission form follows the comparative analysis format specified at 42 U.S.C. 300gg-26(a)(8)(A); 29 U.S.C. 1185a(a)(8)(A); 26 U.S.C. 9812(a)(8)(A).

Step 1: Specify the specific plan or coverage terms or other relevant terms regarding the NQTL, that applies to such plan or coverage, and provide a description of all mental health or substance use disorder (MH/SUD) and medical or surgical benefits to which the NQTL applies.

FAQ 45 Guidance: The FAQ 45 (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Simply insert "same as _____" whenever an entry is identical to another entry

Inpatient, in-network:

Inpatient, out-of-network:

Outpatient, in-network:

If subclassifications are used

Office visit:

Outpatient other:

Outpatient, out-of-network:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify all the factors used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Simply insert "same as _____" whenever an entry is identical to another entry

Inpatient, in-network:

Inpatient, out-of-network:

Outpatient, in-network:

If subclassifications are used

Office visit:

Outpatient other:

Outpatient, out-of-network:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Simply insert "same as _____" whenever an entry is identical to another entry

Inpatient, in-network:

Inpatient, out-of-network:

Outpatient, in-network:

If subclassifications are used

Office visit:

Outpatient other:

Outpatient, out-of-network:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is appropriate for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Simply insert "same as _____" whenever an entry is identical to another entry

Inpatient, in-network:

As written:

In operation:

Inpatient, out-of-network:

As written:

In operation:

Outpatient, in-network:

As written:

In operation:

If subclassifications are used

Office visit:

As written:

In operation:

Outpatient other:

As written:

In operation:

Outpatient, out-of-network:

As written:

In operation:

If subclassifications are used

Office visit:

As written:

In operation:

Outpatient other:

As written:

In operation:

Emergency:

As written:

In operation:

Prescription drug:

As written:

In operation:

Step 5: The specific findings and conclusions reached by the plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

FAQ 45 Guidance: The FAQ 45 guidance states that a sufficient response should include:

(Q2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Simply insert "same as _____" whenever an entry is identical to another entry

Inpatient, in-network:

Inpatient, out-of-network:

Outpatient, in-network:

If subclassifications are used

Office visit:

Outpatient other:

Outpatient, out-of-network:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Appendix B: Reporting form for quantitative data analysis

The reporting form for the quantitative data analysis was provided as a Microsoft Excel workbook to each insurer. Access to the reporting form can be found on the DFR mental health parity webpage located at https://dfr.oregon.gov/business/reg/health/pages/mental-health-parity.aspx.