Department of Consumer and Business Services

Report on Mental Health Parity
As Required by House Bill 3046 (2021)

September 15, 2022

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

About Oregon DFR:
The Division of Financial Regulation protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and services and is part of the Department of Consumer and Business Services. Visit dfr.oregon.gov.

This report is based on information and data collected by DFR from insurance companies through June 2022.

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Executive Summary

In recent years, access to behavioral health and substance use disorder treatment services has become a top priority for Oregon policymakers. As part of a broad effort to improve consumer access to needed services, the Oregon Legislative Assembly passed House Bill 3046 (2021), which expands upon and clarifies existing mental health parity requirements in state and federal law.

This new law requires the Department of Consumer and Business Services (DCBS) to report to the interim committees of the Oregon Legislative Assembly related to mental or behavioral health by Sept. 15 of each year, comparing health insurance carriers' coverage of mental health treatment and services, and substance use disorder treatment and services, to carriers' coverage of medical or surgical treatments or services. This report is to be based on new annual reporting requirements for issuers of health benefit plans in Oregon. The department received the first reports under the new law in May 2022.

Key findings from the department's review of these reports include:

- On average across the commercial health insurance market, claim denial rates for behavioral health and medical-surgical services are similar. However, there is wide variation across health insurance carriers, with some denying behavioral health claims at a greater frequency.

- Provider reimbursement rates were reported on average to be lower for behavioral health providers than for medical-surgical providers for office visits of comparable length. Reimbursement rates also vary significantly between provider types. More information is needed to evaluate these variations in methodology.

- Insurers reported that nonquantitative treatment limits (NQTLs) were applied the same to both behavioral health and medical-surgical benefits. However, insufficient data was provided to confirm parity in the application, as well as on how stringently an NQTL may apply to behavioral health benefits.

- Reporting and data quality issues make a thorough parity analysis of health insurance carriers' NQTLs challenging. Similar issues have hampered federal mental health parity reporting efforts. The department will work closely with carriers to improve reporting in this area in future years.

As this is the first year of reporting under HB 3046, there are limitations to the current report, such as a lack of historical data to reference. Future reports will provide a more detailed analysis, as DCBS will be able to make year-over-year comparisons.

Background

Coverage and access to mental health services are critical to providing care when it is needed. In Oregon, the share of adults with any mental illness was 23.8 percent from 2018 to 2019. [1] More recently, 34.6 percent of Oregonians reported symptoms of anxiety or depression in 2021 with 34.5 percent of those reporting symptoms experienced an unmet need for mental health counseling or therapy.[2] Overall, in Oregon, there is a ratio of one mental health provider for every 170 people (170:1); however, disparities exist for a variety of reasons, such as geography. For example, Gilliam County has a ratio of 660:1.[3]

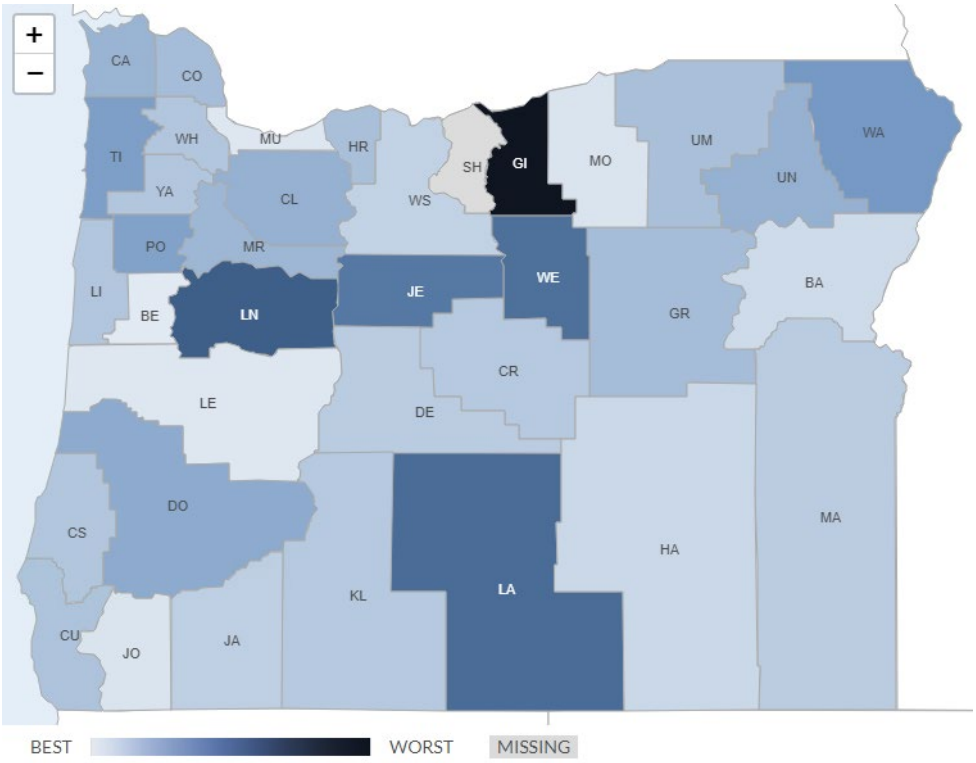

Figure 1. Ratio of population to mental health providers by county in 2021.
Source from University of Wisconsin Population Health Institute.

In addition to geographic disparities, access barriers exist related to race and cultural background. Stakeholders in one survey in Multnomah County note that the majority of mental health professionals are white and there are limited bilingual or multilingual providers.[4] These disparities and how communities are affected by barriers provide important context to evaluating coverage and access to the mental health services Oregonians need.

[1] Kaiser Family Foundation. "Mental Health in Oregon." Accessed Sept. 3, 2022.
[2] *Ibid.*
[3] University of Wisconsin Population Health Institute - County Health Rankings. "Oregon: Mental Health Providers." Accessed Sept. 3, 2022.
[4] Human Services Research Institute. "Multnomah County Mental Health System Analysis – Draft Final Report." June 2018. Accessed Sept. 3, 2022.

Several tools exist to monitor, measure, and evaluate access to mental health services, including analyzing parity in coverage for mental health services. Under state and federal law, mental health parity generally requires that the conditions and limitations placed by insurance companies on mental health services must be the same as those placed on medical and surgical services. Before the enactment of these laws, many health plans restricted access to mental health services with limits on annual outpatient visits, number of inpatient days, and a higher cost sharing attributed to accessing these services.[5] These issues and others prompted Congress to enact legislation to address parity between mental health coverage and medical-surgical coverage.

Federal legislation

The Mental Health Parity Act (MHPA) of 1996 was the first major federal initiative to address mental health coverage in group health plans. Under MHPA, group health plans could not impose lower lifetime coverage limits on mental 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 the amount of actual coverage provided. The law also did not address substance use disorder (SUD) 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.[6]

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 mental health benefits, and the requirement for parity with medical benefits for all cost-sharing levels, including co-pays, co-insurance, and deductibles. The Act 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). However, MHPAEA does not require that plans cover mental health and substance use disorder treatments, only that if a plan covers treatment, that treatment be covered at parity to other benefits.

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, 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.[7] Some insurers are working actively to make changes while working through corrective action plans with the federal agencies.

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[5] Barry, Colleen L., Haiden A. Huskamp, and Howard H. Goldman. "A Political History of Federal Mental Health and Addiction Insurance Parity." *Millbank Quarterly,* volume 88(2010). Accessed Sept. 4, 2022. *https*://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754/.

[6] United States Department of Labor. Fact Sheet: The Mental Health Parity Act. Accessed Aug. 8, 2022.

[7] Department of Labor, Department of Health and Human Services, and Department of the Treasury. "2022 MHPAEA Report to Congress". Accessed Sept. 4, 2022.

Oregon legislation

Oregon enacted mental health parity laws beginning in 1975, and the statute has undergone numerous changes since first enacted. The state's mental health parity laws had not been significantly amended since 2005, when the requirements of the existing mandate were 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. The department issued a bulletin in 2014, providing guidance to insurers about the expectations for insurers in implementing state and federal mental health mandates.[8]

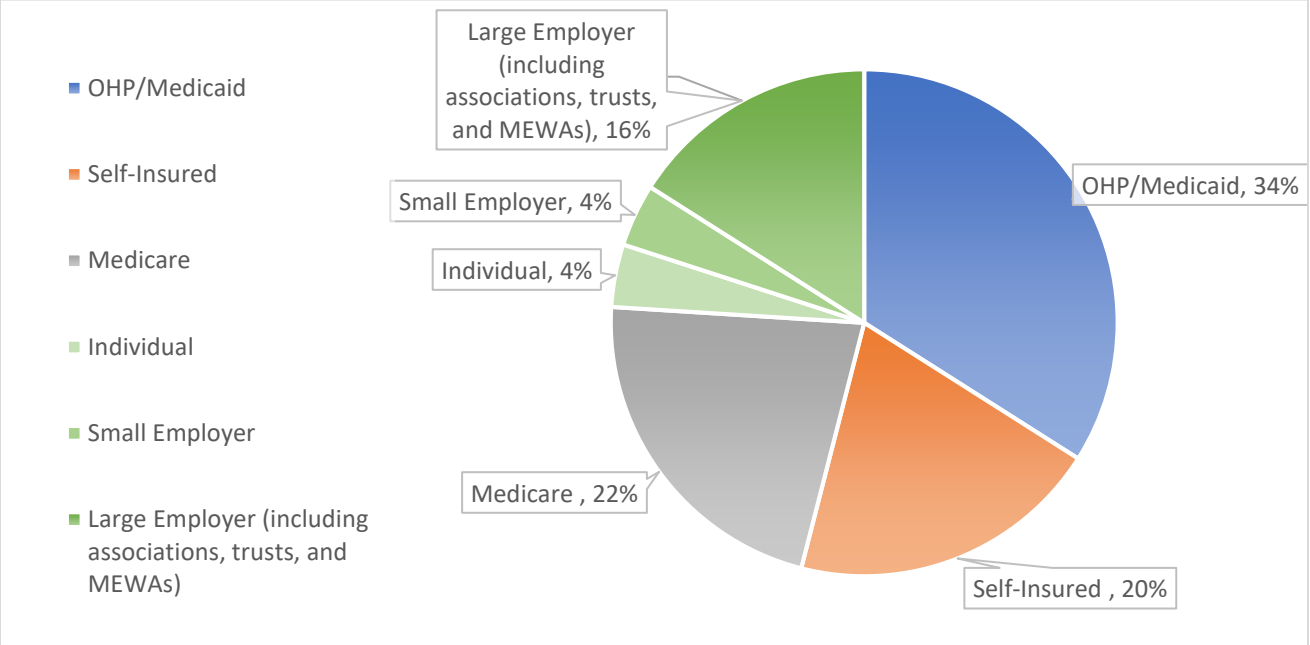
In 2021, the Oregon Legislature passed House Bill 3046, which provides clarity on the services covered by mental health parity and specifies requirements for the use of nonquantitative treatment limits.[9] The bill requires each carrier that offers an individual or group health benefit plan that provides behavioral health benefits to annually analyze nonquantitative treatment limitations for behavioral health benefits. Carriers must report to the department each year on nonquantitative treatment limitations for mental health and substance use disorder, and applicable medical or surgical benefits. The bill requires the department to report to the interim committees of the legislative assembly related to mental or behavioral health by Sept. 15 of each year, comparing carriers' coverage of mental health treatment and services, and substance use disorder treatment and services, to carriers' coverage of medical or surgical treatments or services.

Insurance market and benefits in Oregon

Specific insurance plans are regulated by different agencies with regard to mental health parity. This report focuses on the commercial health insurance market, which DCBS regulates. As of June 2022, approximately 1 million people were enrolled in Oregon commercial health insurance plans regulated by DCBS, which represents approximately 25 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 payor type.

[8] Division of Financial Regulation. Bulletin INS 2014-1.
[9] HB 3046, 2021 Regular Session (OR 2021),

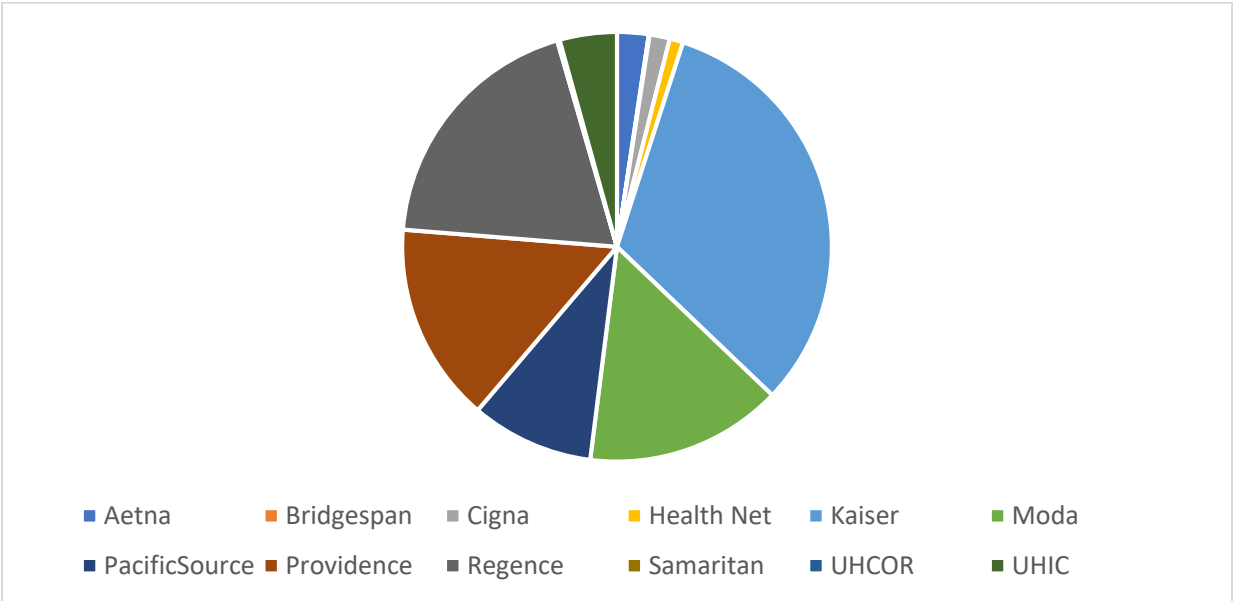
Figure 2. Oregon health insurance enrollment by market and payor type.



Data collected by DFR in 2022.

Self-funded group plans are regulated by the U.S. Department of Labor and are subject to the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Other mental health parity requirements for Medicaid are regulated by the Oregon Health Authority. The graph below illustrates market share for the leading companies statewide. Kaiser Permanente, Regence BlueCross BlueShield of Oregon, Providence, and Moda Health are the four largest commercial health insurance companies in Oregon.

Figure 3. Oregon state-regulated commercial health insurance companies by market share.



Data collected by DFR in 2022.

Oregon's mental health parity law requires health benefit plans to cover behavioral health services "at the same level" and with treatment limitations "no more restrictive" than what is in place for other medical services. The law provides clarity on the applicability of mental health parity to specific services and specifies requirements for the use of nonquantitative treatment limits. It also requires insurers to conduct an analysis and report to the division factors related to coverage, claims handling, utilization management, comparison to medical/surgical benefits, and reimbursement.

The Division of Financial Regulation (DFR), the state's insurance regulator housed within DCBS, convened a rule advisory committee (RAC) to draft rules related to implementing HB 3046. Rules for behavioral health benefit reporting requirements were adopted in February 2022. [10] The rules require an insurer offering individual or group health benefit plans to submit its annual report for behavioral health benefits to the department by March 1 of each year. As this was the first year of reporting, insurers were granted an extension for submitting the annual report. In May 2022, DFR received reports from all insurers subject to the reporting requirement. Outlined in the sections below are the results and analyses of the data reported by health insurers.

Findings – Nonquantitative treatment limits

MHPAEA regulations state that a health insurer may not impose NQTLS on behavioral health benefits unless these limits are implemented comparable to and applied no more stringently than medical-surgical benefits. DFR received self-reported data from insurers and reviewed it to determine if follow-up questions were necessary. Nearly all insurers required more follow-up to clarify the information received regarding NQTLs with varying responses back, including no response or duplication of responses to what was initially submitted, which was insufficient to make definitive determinations about parity in the market.

As this is the first year of reporting on mental health parity, there are other limitations to the report, such as a lack of historical data to reference. Future reports will provide a more detailed analysis as DFR will be able to make year-over-year comparisons. In addition, the division will continue to refine the data collection process, including working with insurers to improve data quality in preparation for the next year of reporting.

Types of NQTLs

A plan may not impose a nonquantitative treatment limit (NQTL) on mental health benefits, unless the processes, strategies, and evidentiary standards used in applying the NQTL to mental health or substance abuse benefits in the classification are comparable to, and are applied no

[10] Behavioral health benefit reporting requirements, Or Laws 2021, ch. 629, https://dfr.oregon.gov/laws-rules/Documents/id01-2022_rule-order.pdf.

more stringently than, those used in applying the NQTLs to medical benefits in the same classification. Examples of NQTLs include the following:

- Medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective
- Exclusions based on failure to complete a course of treatment
- Coverage restrictions based on geographical location, facility type and provider specialty, and other criteria that limit the scope or duration of benefits for services

Insurers are required to provide specific plan or coverage terms regarding NQTLs application to mental health and medical-surgical benefits. This needs to include the factors used to determine the application and any evidentiary standards used for every NQTL utilized. Oregon insurers reported using several different types of NQTLs, including prior authorization, concurrent review, fail-first policy, medical necessity, geographic restrictions, and provider credentialing. Many insurers described at times the same NQTL in different ways by either referring to the specific NQTL differently or reporting multiple NQTLs within one report. DFR is in the process of determining how to objectively report NQTLs for future reports in standard categories.

Evidentiary standards

Insurers were required to report the evidentiary standard used for the NQTL factors and any other sources used to design or apply NQTLs for both behavioral health and medical-surgical benefits. Different evidentiary standards were used by each insurance company. In reviewing the NQTL reports, most insurers use common evidentiary standards such as the American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), and Child and Adolescent Level of Care Utilization System (CALOCUS). A couple insurers reported using Milliman Care Guidelines. Several insurers reported evidentiary standards only for some NQTLs and not for others. This limits the analyses for evidentiary standards as applied to all NQTLs for behavioral health and medical-surgical benefits. Similar issues with reporting were noted in the 2022 MHPAEA Report to Congress for other health insurers and health insurance markets.[11]

Comparative analysis of behavioral health and medical-surgical benefits

The final component of the NQTL reporting required insurers to provide a comparative analysis, demonstrating that the processes, strategies, evidentiary standards, and other factors used to

[11] Department of Labor, Department of Health and Human Services, and Department of the Treasury. "2022 MHPAEA Report to Congress". Accessed Sept. 4, 2022.

apply the NQTLs to behavioral health benefits were no more stringent than NQTLs used for medical-surgical benefits. Many insurers provided statements that the NQTLs reported were used for both behavioral health and medical-surgical benefits. However, these statements and the analyses lacked detail to sufficiently evaluate a comparison on how these NQTLs were applied to both benefits and if any were applied more stringently to behavioral health benefits. These limitations affect the division's ability to determine any conclusions about NQTL application and parity between behavioral health and medical-surgical benefits. These are issues that the federal agencies and other states have experienced as well during the first year of compliance reporting for MHPAEA. DFR is working to identify how to improve and further clarify reporting standards for sufficient NQTL analyses in future reports.

Findings – Claims, denials, and provider rates

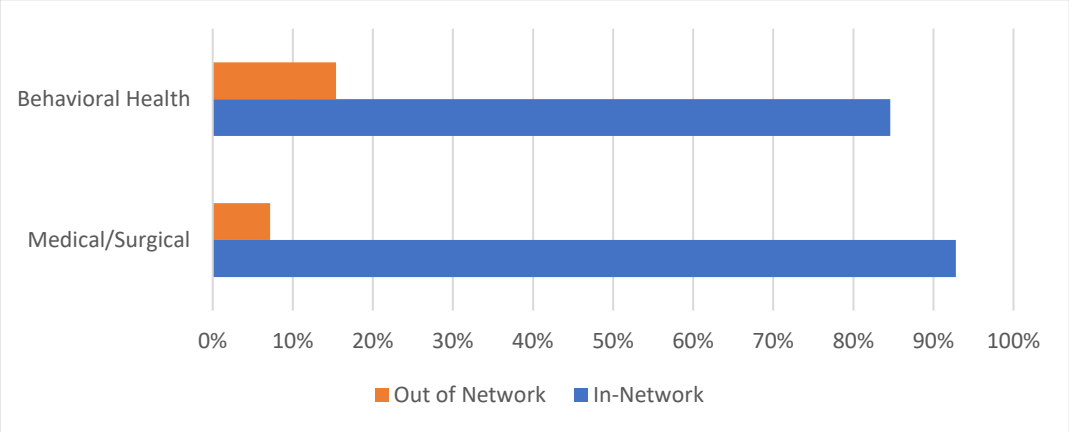
Oregon law requires quantitative reporting for denials, claims, and the median maximum allowable reimbursement rate for behavioral health benefits and medical and surgical benefits. Insurers are also required to report on findings or conclusions demonstrating compliance with the MHPAEA and ORS 743A.168, as well as any other data or information the department deems necessary. The quantitative reporting requirements are in place until 2025. Insurers used a form created by DFR and posted to the division's website to report the quantitative data described below. Information reported to the division was on claims and rates during 2021.

Claims

During the reporting period, there were four times as many claims (including for health care services delivered via telehealth) submitted for medical-surgical services as there were for behavioral health and substance abuse disorder services. The figure below shows the overall number of claims for both service types as reported by all 12 insurers. Across all insurers, the number of medical-surgical claims was larger than the number of behavioral health claims at a ratio of 4.38 medical-surgical claims for every one behavioral health claim (4.38:1).

The majority of paid claims for both behavioral health and medical-surgical services were paid to in-network providers. However, the average percentage of claims paid to out-of-network behavioral health providers (15.4 percent) was higher than those paid to out-of-network medical-surgical providers (7.18 percent).

Figure 4. Percentage of claims by type of service and provider network status.



Data collected by DFR in 2022.

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. Behavioral health claims were more likely to be submitted as a telehealth claim than medical-surgical claims. The table below displays the total claims, total telehealth claims, and the percentage of claims that were submitted as telehealth.

Figure 5. Summary data on aggregate claims and telehealth claims for all insurers.

	Total claims	Total telehealth claims	Total percentage
Behavioral health	1,262,269	925,221	73.30%
Medical-surgical	5,524,081	790,584	14.31%

Data collected by DFR in 2022.

Denials

Average denials for all insurers are similar between behavioral health and medical-surgical claims; however, when evaluating individual companies, the denial ratios were different at times. Therefore, the division is unable to determine if there is parity overall regarding the denial of claims between behavioral health and medical-surgical claims. The total number of claims for behavioral health services was reported to be 1,262,269, while the total number of denials was 110,519, which gives an average rate of denial of 8.76 percent. In comparison, the total number of claims for medical/surgical services was 5,524,081, while the total number of denials was 484,535, which gives an average rate of denial of 8.77 percent.

There is significant variance when examining denials by company. Ratios of claims submitted to claims denied were different between companies. Smaller ratios generally indicate that a denial occurs more often versus higher ratios, which indicate the opposite. Some insurers have smaller total numbers of claims which would factor into a smaller claims ratio. For behavioral health claims, the smallest ratio for claims submitted to denials was 1.37:1 and the largest was 3,499.6:1. Differences in ratios between companies also were observed for medical-surgical denials.

Figure 6. Ratio of claims to denials for behavioral health and medical-surgical claims.

	Smallest claims to denials ratio	Average claims to denials ratio	Largest claims to denials ratio
Behavioral health	1.37	305.1	3,499.6
Medical-surgical	2.71	23.0	98.5

Data collected by DFR in 2022.

Some insurers had ratios between behavioral health and medical-surgical denials that were fairly similar. For example, the ratio for behavioral health was 10:1 and medical-surgical was 12:1. Other insurers had larger differences when comparing behavioral health to medical-surgical or vice-versa. These variances indicate the need for additional follow-up questions and data validation, as well as more work to determine whether further information is needed to evaluate parity as it relates to the claims denials.

Provider rates

Insurers reported information on provider rates as the median maximum allowable rate for incurred claims during 2021. In future years, these reports may include the contracted provider rates, as well as 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 median of all maximum allowable reimbursement rates, minus incentive payments…".[12] These rates were reported in several forms by current procedural terminology (CPT) codes list on the division's website.[13] Provider rates were submitted by CPT code and provider type for both in network and out of network, as well as geographic region.

In network

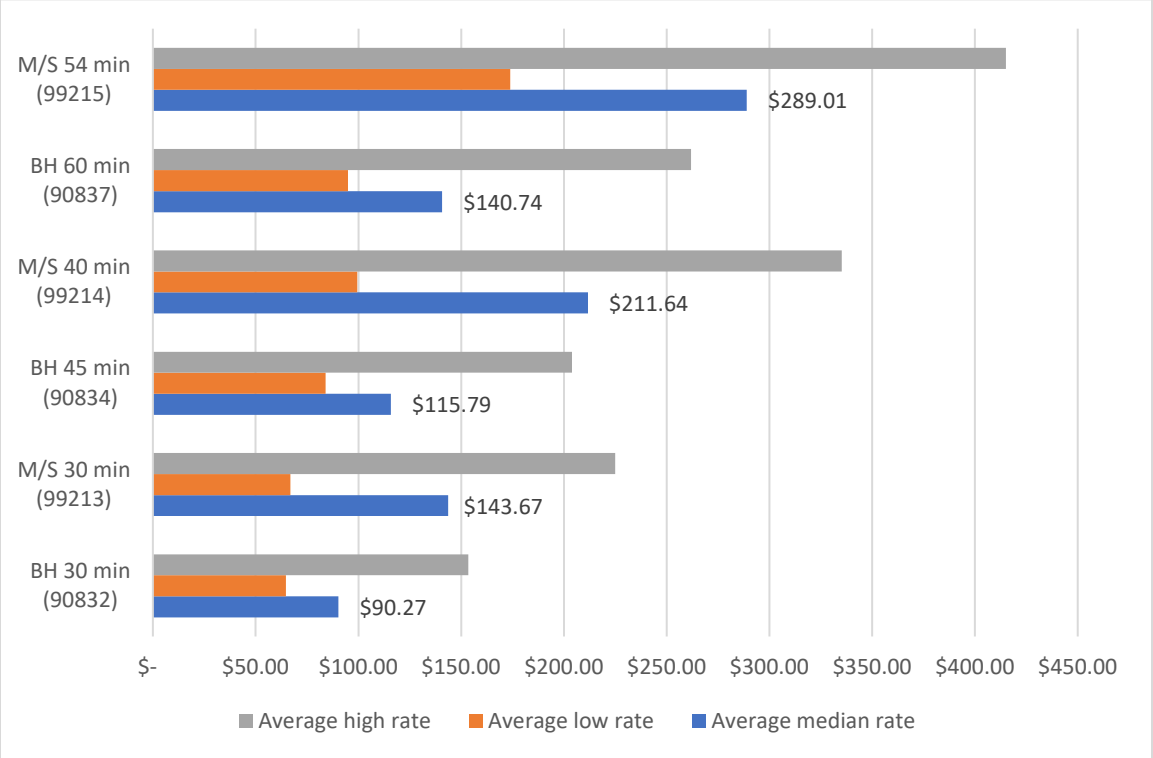
Rates were reported by each company for CPT codes related to office visits and other common procedures that occur within both behavioral health services and medical-surgical services. The U.S. Department of Labor provides a framework for insurers to use to analyze provider reimbursement rates to determine 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-

[12] OAR 836-053-1425(4).
[13] Oregon Division of Financial Regulation. "HB 3046 Annual Reporting CPT Code List". Accessed September 6, 2022.

surgical providers or an external benchmark, such as Medicare rates.[14] 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.

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

Figure 7. Average in-network reimbursement rates for behavioral health (BH) and medical-surgical (M/S) office visit by CPT code.



Data collected by DFR in 2022.

The difference between the average median reimbursement rate for a psychotherapy visit with a behavioral health provider versus an office visit with a medical-surgical provider is approximately $99.18. As stated above in guidance on provider reimbursement, differences in rates are an indication for further evaluation of reimbursement methodology.

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. There are some provider types who use CPT codes for both behavioral health psychotherapy office visits and medical-surgical office visits. Interestingly, provider types seem to

[14] Department of Labor. "Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)." Accessed, Sept. 4, 2022.

have smaller differences within the same CPT code where reimbursement rates are more comparable to other provider types when they use the specific CPT code.

Figure 8. Average in-network reimbursement rates for behavioral health (BH) and medical-surgical (M/S) office visit by provider type.

	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	$71.60	$90.36	$110.96	$144.47	$224.54	$302.24
Marriage and family therapist	$69.73	$93.82	$117.10	$151.70	$205.81	$277.36
Nurse practitioner	--	--	--	$145.68	$220.00	$293.80
Professional counselor	$66.59	$91.66	$110.16	$161.47	$217.66	$302.24
Physician assistant	--	--	--	$153.37	$224.24	$296.89
Physician	--	--	--	$147.32	$220.69	$294.72
Nurse practitioner - psychiatric mental health	$118.43	$153.53	$197.45	$125.41	$173.89	$253.67
Psychologist	$105.65	$124.56	$150.83	$124.36	$175.06	$335.42
Psychiatrist	$115.31	$159.30	$183.25	$126.96	$192.99	$278.49
Reg. interns	$76.31	$123.33	$143.66	$182.50	$240.00	$326.75
Average rate	$89.09	$119.51	$144.77	$146.32	$209.49	$296.16

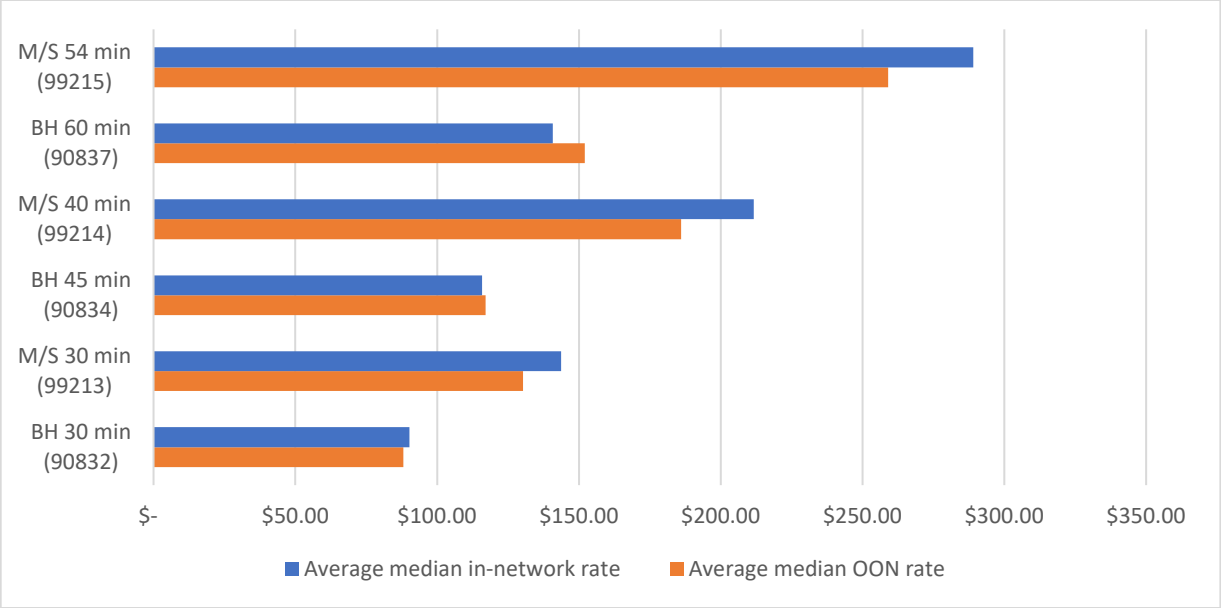
Data collected by DFR in 2022.

When comparing provider types there seem to be smaller differences within the same CPT code where reimbursement rates are more comparable to other provider types. The differences between the CPT codes for behavioral health and medical-surgical still exist. It is difficult to make definitive conclusions about reimbursement rate methodologies on the basis of this data. However, it indicates further investigation is warranted to understand these differences for CPT codes and provider types.

Out-of-network

Insurers reported on the average of median out-of-network reimbursement rates for the same CPT codes and provider types. Average of median out-of-network reimbursement rates were reported to be similar to the in-network rates. The CPT codes relating to 45-minute and 60-minute behavioral health psychotherapy had slightly lower in-network reimbursement rates as compared to the out-of-network rates.

Figure 9. Comparison of average in-network and out-of-network reimbursement rates for behavioral health (BH) and medical-surgical (M/S) office visit by CPT.



Data collected by DFR in 2022.

Out-of-network reimbursement rates were also reported by provider type. Most out-of-network reimbursement rates were lower than the in-network rates, which is consistent with provider feedback. The table below displays the in-network and out-of-network reimbursement rates for 30-minute psychotherapy or medical-surgical office visits by provider type.

Figure 10. Average of median in-network and out-of-network reimbursement rates for 30-minute behavioral health (BH) and medical-surgical (M/S) 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	$71.60	$74.79	$144.47	$82.80
Marriage and family therapist	$69.73	$68.34	$151.70	$82.80
Nurse practitioner	--	--	$145.68	$121.90
Professional counselor	$66.59	$76.08	$161.47	$98.53
Physician assistants	--	--	$153.37	$132.11
Physicians	--	--	$147.32	$134.04
Nurse practitioner - psychiatric mental health	$118.43	$96.17	$125.41	$126.65
Psychologist	$105.65	$107.71	$124.36	$157.06
Psychiatrists	$115.31	$100.57	$126.96	$114.86
Reg. interns	$76.31	$97.04	$182.50	$165.00

Data collected by DFR in 2022.

In a couple instances, the out-of-network reimbursement rate was higher than the in-network rate for certain providers. This is an area for the division to look into further to understand if there are issues out-of-network reimbursement for certain providers billing medical-surgical office visits.

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 geographic rating areas for health benefit plans.[15] Most CPT codes were either close or higher than 100 percent of the Medicare rate for the region. The table below displays the average of median reimbursement rates for 30-minute psychotherapy or medical-surgical office visits by geographic region.

Figure 11. Average of median in-network reimbursement rates for 30-minute behavioral health (BH) and medical-surgical (M/S) office visit by geographic region.

	BH 30 min (90832)		M/S 30 min (99213)	
Geographic region	**Reimbursement rate**	**% of Medicare rate**	**Reimbursement rate**	**% of Medicare rate**
Portland metro	$86.50	114.81%	$139.16	146.59%
Mid-Willamette	$85.36	117.57%	$148.80	157.91%
Marion-Polk	$79.58	111.26%	$141.79	155.29%
Central-southern Cascades	$76.46	101.39%	$131.37	141.99%
North and south coast	$77.13	111.04%	$131.77	147.33%
Central-eastern	$74.68	98.65%	$126.50	138.64%
Southern Willamette	$80.97	107.78%	$158.85	173.28%

Data collected by DFR in 2022.

In reviewing the other CPT codes for 45- and 60-minute visits, all but one were more than the 100 percent Medicare rate. Reimbursement for 60-minute psychotherapy visit was reported to be less than the 100 percent Medicare rate, but higher than 90 percent for all geographic regions.

As stated above in guidance around provider reimbursement, differences in rates are an indication for further evaluation of reimbursement methodology. The division will continue to engage in work to determine any issues, discrepancies, or nuances regarding provider reimbursement methodology.

[15] Oregon Division of Financial Regulation. "Oregon Geographic Rating Areas". Accessed Sept. 6, 2022.

Conclusion

The division is closely working with other state insurance regulators, all focused on continuously improving mental health parity evaluation and compliance through the National Association of Insurance Commissioners MHPAEA (B) Working Group. The MHPAEA (B) Working Group provides a national clearinghouse of mental health parity information, including, but not limited to, evaluation tools, best practices, and lessons learned from other states, federal regulators, and national nonprofits.

The division is considering contracting with an experienced and objective mental health parity consultant to review the division's current MHP evaluation process, including the 2021 QTL and NQTL reports from insurers to provide the division with recommendations for process improvement.

Since this is the first year of reporting on mental health parity, future reports will include a more detailed analysis. DFR will be able to draw comparisons from the past year's report. The division will continue to refine the data collection process, including working with insurers to improve data quality in preparation for the next year of reporting.

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 Or 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 (Q 2, # 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 (Q 3, # 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.

(Q 2, # 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:

(Q 3, # 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.

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

(Q 3, # 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:

(Q 2, # 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:

(Q 3, # 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/Documents/mental-health-parity/annual-MHP-reporting-template.xlsx