Report on Behavioral Health Parity

As required by House Bill 3046 (2021)

DCBS | Department of Consumer and Business Services

Sept. 15, 2024

About DCBS:
The Department of Consumer and Business Services (DCBS) 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 (DFR) protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and service and is part of DCBS. Visit dfr.oregon.gov.

This report is based on information and data collected by DFR from insurance companies through December 2023.

Acknowledgments

This report was prepared by and with help from the following staff at the Division of Financial Regulation within the Department of Consumer and Business Services:

Lisa Emerson, senior health policy analyst

Brooke Hall, senior health policy analyst

Colette Hittner, lead field examiner

Michael Holmes, market analyst

Spencer Peacock, lead data analyst

Marc Rivers, data analyst

Jason Saldivar, market analyst

Tashia Sizemore, life and health program manager

Jesse O'Brien, policy manager

Table of contents

Executive summary **5**
Introduction 5
Key findings 5
Introduction **7**
Purpose of the report 7
Methodology 7
Transition in data reporting requirements 7
Background **8**
Federal legislation 9
Oregon legislation 9
Insurance market and benefits in Oregon 10
Findings – nonquantitative treatment limitations (NQTL) **11**
Overview of NQTLs 11
Key observations for 2024 11
Findings – claims, telehealth, denials, and provider rates **14**
Claims 14
Telehealth 16
Denials 17
Provider reimbursement rates **19**
In-network 19
Out-of-network 22
Geographic rate 25
Conclusion **28**
Appendix A: Reporting Form for NQTL Analysis **29**
Appendix B: Reporting form for quantitative data analysis **29**

Executive summary

Introduction

The ongoing challenge of ensuring behavioral health/substance use disorder services are provided at parity with medical/surgical services is a critical issue in Oregon. This executive summary highlights the key findings from the 2024 report, which assesses the compliance of health benefit plan insurers with state and federal parity laws. The report delves into the application of nonquantitative treatment limitations (NQTLs), claims processing, telehealth utilization, and provider reimbursement practices. The findings reveal progress in some areas, but also underscore disparities that continue to affect equitable access to behavioral health services. This summary provides an overview of the most critical issues identified in the report.

Key findings

1. **Nonquantitative treatment limitations (NQTLs):** An NQTL is a limit on the amount, duration, or scope of behavioral health/substance use disorder benefits not quantified by specific numbers of visits, days, or units of service. The information below provides an overview of key findings related to the application, variability, and challenges associated with NQTLs for 2024.

    - Application and variability: Insurers use various internal and external data sources to inform NQTLs, including evidence-based criteria such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the American Society of Addiction Medicine (ASAM) criteria. However, there is significant variability in the application of these standards, particularly with behavioral health services. Issues such as transparency in reporting and inconsistencies in data provided by insurers complicate efforts to ensure that NQTLs are applied equitably.
    - Medical management standards: These standards, including prior authorization and medical necessity criteria, are applied differently across insurers. Some enforce stricter standards for behavioral health/substance use disorder benefits compared to medical/surgical benefits, often considering factors such as treatment costs and the potential for overutilization. This variability can result in reduced access to care for behavioral health services.
    - Formulary design: Insurers often impose more restrictive policies on behavioral health/substance use disorder medications compared to medical/surgical medications. Off-label prescribing restrictions and formulary exclusions can disproportionately affect behavioral health/substance use disorder patients, limiting access to necessary treatments.
    - Provider network admission and access: Maintaining adequate networks of behavioral health providers remains a challenge, especially in rural areas. Some insurers have expanded telehealth services to increase accessibility, but questions remain about the adequacy of in-person care options.

2. **Claims and telehealth utilization:**

    - **In-network utilization:** There has been a positive trend toward increased use of in-network providers for behavioral health and medical/surgical services. In 2023, 94.75 percent of behavioral health claims were paid to in-network providers, narrowing the gap with medical/surgical services.
    - **Telehealth adoption:** Telehealth has become a critical tool in expanding access to behavioral health services. In 2023, 68.63

percent of all behavioral health claims were telehealth claims, compared to just 6.21 percent for medical/surgical services. However, there is significant variability in telehealth adoption across insurers.

3. **Denials and appeals:**

- **Denial rates**: Behavioral health services typically face higher denial rates compared to medical/surgical services. However, despite the higher denial rates, the percentage of appeals filed for behavioral health claims tends to be lower than for medical-surgical claims.
- **Trends over time:** The number of denials for behavioral health services has generally decreased over time, while denials for medical/surgical services have increased. The success rate of appeals has fluctuated, highlighting the need for ongoing monitoring.

4. **Provider reimbursement rates:**

In-network rates:
The 2023 in-network reimbursement rate data reported by insurers for comparable time-based office visit current procedural terminology (CPT) codes show that from 2022 to 2023:

- The average of median in-network reimbursement rates for medical/surgical office visit CPT codes were reported to be higher than behavioral health office visit CPT codes.
- The average of median in-network reimbursement rate increased for both behavioral health and medical/surgical providers; however, the increase for behavioral health providers was approximately $5.31 less than the medical/surgical providers increase.

Out-of-network rates:
The 2023 out-of-network reimbursement rate data reported by insurers for comparable time-based office visit CPT codes show that from 2022 to 2023:

- The reported average of median out-of-network reimbursement rates for comparable behavioral health and medical/surgical office visit CPT codes were lower than in-network rates.
- The average of median out-of-network reimbursement rate increased for both behavioral health and medical/surgical providers; however, the increase for behavioral health providers was approximately $8.04 less than the medical/surgical providers increase.

Geographic rates:
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. From 2022 to 2023:

- The median reimbursement rate for behavioral health office visit (CPT 90832) increased for all regions, except for a slight decrease in region No. 7 (Southern Willamette).
- The median reimbursement rate for 30-minute medical/surgical office visit (CPT 99213) increased for all regions.

The comparable 30-minute behavioral health and medical/surgical office visit CPT codes are both more than 100 percent of the Medicare reimbursement rate for all seven of Oregon's geographic regions. From 2022 to 2023:

- Behavioral health provider geographic region rates as a percent of the Medicare rate for CPT 90832 increased in every geographic region, except for a slight decrease in region No. 4 (Central-Southern Cascades).
- Medical-surgical provider geographic region rates as a percent of the Medicare rate for CPT 99213 increased in every geographic region.

Introduction

Purpose of the report

This report is prepared in compliance with House Bill (HB) 3046, which requires DCBS to annually assess and report to the legislative assembly on the compliance of health benefit plan insurers with behavioral health parity laws. It presents the findings from an analysis of data provided by insurers offering health benefit plans in Oregon that include behavioral health coverage. The report's purpose is to evaluate insurer compliance with HB 3046 and identify any disparities in coverage between behavioral health and substance use disorder treatments compared to medical/surgical treatments.

Methodology

The data collection process for this report included steps to ensure the accuracy and completeness of the findings. DCBS maintained a rigorous data collection process that started with gathering information from multiple sources, such as insurers' self-reported data, feedback from providers, and consumer complaint information. Insurers who had errors in reported data were instructed to provide updates. This year, department staff completed training on methods of assessing federal behavioral health parity requirements. While reviewing the information provided by insurers, the department worked with each insurer individually to address specific concerns with the information reported by their organization and obtain additional information when necessary. The information reported by insurers was reviewed and analyzed to assess their compliance with the requirements of HB 3046. The findings of this report are based on the data collected and analyzed by the department.

Transition in data reporting requirements

It is important to note that, due to statutory changes, many of the quantitative data elements insurers are required to report will no longer be mandated after Jan. 1, 2025. Specifically, the sunset provisions will end the requirement for insurers to report the following data elements in future reports:

- **Denial information:** Data on the number of denials of behavioral health benefits and medical/surgical benefits, including percentages of denials that were appealed, upheld, and overturned.
- **Percentage of claims paid:** The percentage of claims paid to in-network and out-of-network providers for both behavioral health benefits and medical/surgical benefits, including partial payments.
- **Median maximum allowable reimbursement rate:** Insurers will no longer need to report the median maximum allowable reimbursement rate for provider contracted rates and incurred claim rates for each time-based office visit CPT billing code.
- **Time-based office visit reimbursement rates:** The requirement to report time-based office visit reimbursement rates as the median rate by geographic region, including the percentage of Medicare the rate represents, for specified health care providers will be discontinued.

As a result of these changes, future reports, including the 2025 Behavioral Health Parity Report, will no longer include these quantitative metrics. The department will adjust its methodology to ensure compliance with the updated reporting requirements.

Background

Access to behavioral health services remains a critical issue in Oregon. According to the 2023 State of Behavioral Health in America report, Oregon is ranked 48th in the nation for behavioral health service accessibility.[1] Significant contributing factors include a high prevalence of behavioral health conditions among adults and youth. About 25.8 percent of adults in Oregon experience some form of behavioral illness, and 17.9 percent of youth suffer from major depressive episodes.

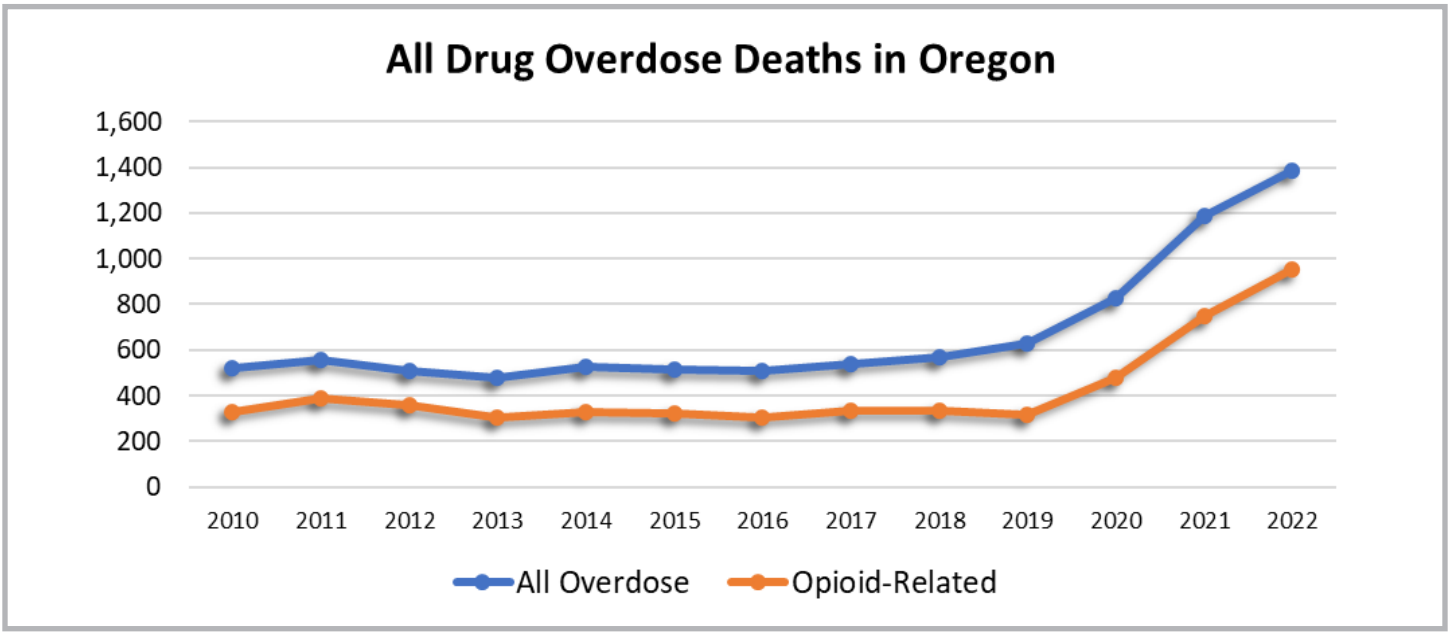
In addition to a high prevalence of behavioral health conditions, Oregon faces a shortage of behavioral health providers. The Health Resources and Services Administration (HRSA) identified more than 120 behavioral health professional shortage areas (HPSAs) across the state, with rural areas being the most affected.[2] HPSAs are regions designated as having a shortage of behavioral health professionals, which may include psychiatrists, clinical psychologists, and clinical social workers. In some rural counties, there are fewer than 10 behavioral health professionals per 100,000 residents, which severely limits access to care.

A report from RTI International provides further insights into these challenges. Using data from the 2019, 2020, and 2021 MarketScan Commercial Database, the report found that out-of-network utilization rates for behavioral health services across the nation are significantly higher than those for medical/surgical services, with patients going out-of-network 3.5 times more often for behavioral health services than for medical/surgical services.[3] This disparity is even greater for visits to a psychiatrist or psychologist, in which patients go out-of-network 8.9 times and 10.6 times more often, respectively. In Oregon, the disparity is even more pronounced, with patients going out-of-network 7.5 times more often for behavioral health services than for medical/surgical services in 2021.

Substance use disorder also presents a significant challenge. According to a report by the Kaiser Family Foundation, drug overdose deaths have increased in Oregon from 13.5 per 100,000 in 2011 to 26.8 per 100,000 in 2021.[4] Over the same period, drug overdose deaths increased from 13.4 to 32.4 per 100,000 in the United States. In addition, the state's capacity to provide adequate treatment is strained, with Oregon needing nearly 3,000 additional residential treatment beds to meet the demand for substance use disorder services.[5] Figure 1 depicts the trends in drug overdose deaths in Oregon from 2010 to 2022, highlighting both the total number of overdose deaths and those specifically related to opioids.

[1] Mental Health America. (2023). *The State of Mental Health in America Statistics 2023*. Accessed June 12, 2024.
[2] Health Resources and Services Administration (HRSA). (2024). *Mental Health Professional Shortage Areas*. Accessed June 12, 2024.
[3] RTI International. (2024). *Behavioral Health Parity- Pervasive Disparities in Access to In-Network Care Continue*. Accessed June 12, 2024.
[4] Kaiser Family Foundation (2023). *Mental Health in Oregon*. Accessed June 12, 2024.
[5] Oregon Health Authority (OHA). (2024). Behavioral Health Residential+ Facility Study. Accessed June 12, 2024.

Figure 1: Overview of all drug overdose deaths in Oregon from 2010 to 2022



The challenges described in this section highlight the need for continued reporting and monitoring of behavioral health parity in Oregon. However, it is important to note, while parity is an essential step toward achieving more equitable access to care, it alone will not solve the deeper, systemic issues such as provider shortages, high out-of-network utilization, and rising substance use disorders. Comprehensive data collection on service utilization, network adequacy, and access is necessary to understand and address these disparities effectively. Additionally, it is vital that parity be supported by other reforms, such as increasing the behavioral health workforce, expanding treatment capacity, and improving rural access to ensure meaningful improvements in care for Oregonians.

Federal legislation

The Mental Health Parity and Addiction Equity Act (MHPAEA), enacted in 2008, built upon earlier federal efforts to improve behavioral health coverage in health insurance plans.[6] This law requires that behavioral health/substance use disorder benefits, when offered, be provided at parity with medical/surgical benefits. This means that cost-sharing, treatment limitations, and coverage restrictions for behavioral health/substance use disorder services should be comparable to those for medical/surgical services.

In 2021, new compliance provisions were added to strengthen the MHPAEA. These provisions require insurers to provide detailed analyses of how they ensure parity in their coverage, particularly regarding nonquantitative treatment limitations (NQLTs). Initial reports revealed that many insurers needed to improve their compliance efforts, and ongoing work continues to align insurance practices with the law's requirements.

Oregon legislation

In 2021, the Oregon Legislature passed HB 3046, which provides clarity on the services covered by behavioral health parity and specifies requirements for the use of nonquantitative treatment limits.[7] The bill requires each insurer that offers an individual or group health benefit plan that provides behavioral health benefits to:

[6] United States Department of Labor. Fact Sheet: The Mental Health Parity Act. Accessed Aug. 8, 2022.
[7] HB 3046, 2021 Regular Session (OR 2021)

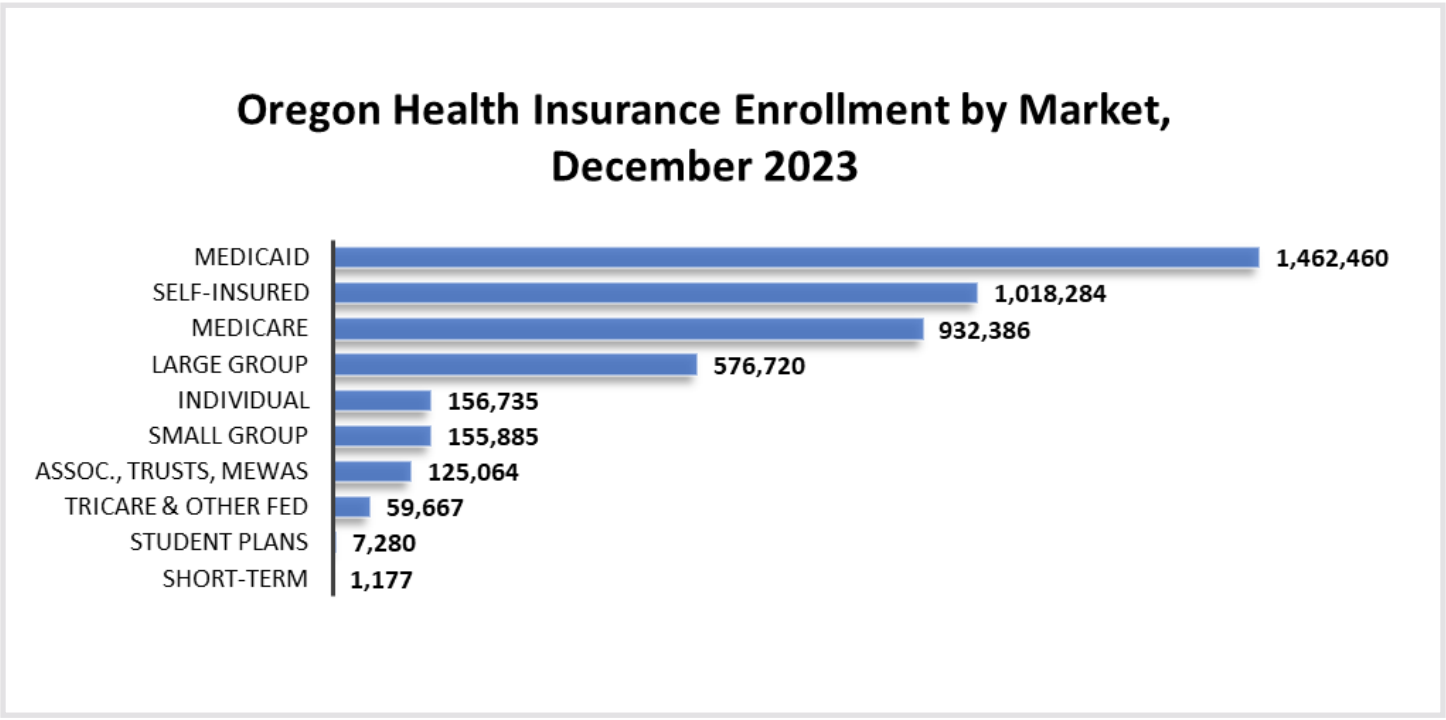
- Annually analyze NQTLs for behavioral health benefits.
- Report to the DCBS on NQTLs for behavioral health/substance use disorder, and applicable medical or surgical benefits.

The bill also 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 insurers' coverage of behavioral health treatment and services, and substance use disorder treatment and services, to insurers' coverage of medical/surgical treatments or services.

Insurance market and benefits in Oregon

Specific insurance plans are regulated by different agencies regarding behavioral health parity. This report focuses on the commercial health insurance market, which DCBS regulates. There are 1,021,684 people enrolled in Oregon commercial health insurance plans regulated by DCBS as of December 2023. The commercial health insurance market includes fully insured large employer group plans, fully insured small employer group plans, individual health benefit plans, ATMs (associations, trusts, and multiple employer welfare arrangements (MEWAs)), and student plans. Figure 2 displays Oregon health insurance enrollment by market and payor type.

Figure 2: Oregon health insurance enrollment by market



Findings – nonquantitative treatment limitations (NQTL)

Overview of NQTLs

An NQTL refers to any restriction or limitation on the availability, scope, or duration of benefits for behavioral health/substance use disorder benefits that is not expressed numerically. NQTLs must be applied comparably between behavioral health/substance use disorder benefits and medical/surgical benefits within the same classification to comply with federal and state parity regulations, such as MHPAEA and HB 3046. Examples of 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 benefits.
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 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 ORS 743A.168, 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 behavioral health/substance use disorder and medical/surgical benefits.

Key observations for 2024

Methods and evidentiary standards:

- Insurers continue to rely on a range of internal and external data sources to inform their NQTLs, including claims data analysis, Medicare rates, and nationally-recognized guidelines such as the Milliman Care Guidelines and ASAM Criteria.
- Evidence-based criteria, such as the DSM-5 and Level of Care Utilization System (LOCUS), are frequently used by insurers to determine the appropriateness, necessity, and level of care for behavioral health/substance use disorder services. These standards help guide decisions on coverage, including whether a specific treatment is medically necessary, what level of care is

required, and how long a patient should receive a particular type of treatment.

- A notable trend is the increasing use of professional judgment committees that incorporate clinical expertise to assess and align policies with established guidelines. These committees play a critical role in ensuring that behavioral health services reflect current clinical practices

Medical management standards:

- Medical management standards, including prior authorization, concurrent review, and medical necessity criteria, are commonly used NQTLs designed to ensure that services are appropriate, effective, and cost-efficient.
- Insurers report varying levels of strictness in applying these standards to behavioral health services compared to medical/surgical services. Some insurers apply the same criteria across both types of benefits, while others enforce stricter standards for behavioral health/substance use disorder benefits.
- The application of medical management standards to behavioral health/substance use disorder services often considers treatment costs, the potential for overutilization, and the risk of fraud, waste, and abuse.

Formulary design and prescription drug management

- Formulary design, which includes tiering and step therapy protocols, represents a significant NQTL for prescription drugs. Insurers frequently restrict access to certain medications by placing them in higher cost-sharing tiers or requiring prior authorization.
- For behavioral health/substance use disorder treatments, insurers generally follow formulary management practices similar to those used for medical/surgical drugs. However, evidence suggests that some insurers impose more restrictive policies on behavioral health/substance use disorder medications, potentially limiting access to necessary treatments.
- Off-label prescribing restrictions and formulary exclusions can disproportionately affect behavioral health/substance use disorder patients, particularly when newer or nontraditional medications are involved.

Provider network admission and access:

- Provider network standards, including credentialing requirements and reimbursement rates, are crucial in determining access to behavioral health/substance use disorder services. Insurers report challenges in maintaining adequate

networks of behavioral health providers, especially in rural or underserved areas.

- Some insurers have implemented telehealth services to expand access to behavioral health care. While telehealth has increased accessibility, it also raises questions about the adequacy of in-person care options.
- Network adequacy remains a significant concern, with several insurers facing challenges in providing sufficient provider options, particularly for specialized behavioral health/substance use disorder services. This often results in increased reliance on out-of-network services, leading to higher costs for patients and delays in receiving care. It is important to recognize that these network issues are, in part, due to broader systemic factors, such as provider shortages, which are outside the direct control of insurers.

Coverage restrictions based on location, facility Type, or provider specialty:

- Insurers often impose limitations on coverage based on the location of services, type of facility, or provider specialty. These restrictions can disproportionately affect behavioral health/substance use disorder services, particularly when services are provided in nontraditional settings or by providers with specialized training.
- Some insurers apply stricter criteria for behavioral health/substance use disorder services based on these factors, which may lead to reduced access to care. For example, certain insurers limit coverage for residential treatment facilities or intensive outpatient programs, requiring more rigorous reviews or stricter medical necessity criteria.

Transparency and reporting of NQTL application:

- Transparency remains an ongoing issue, with insurers varying widely in how they report the application of NQTLs to behavioral health/substance use disorder versus medical/surgical benefits. Some insurers provide detailed data, while others offer generalized statements with little supporting evidence.
- The inconsistency in NQTL reporting makes it challenging to assess whether insurers are meeting parity requirements. In some cases, insurers do not provide enough data to demonstrate that NQTLs are applied comparably across different benefit types, complicating efforts to ensure equal treatment.
- Despite existing requirements, many insurers do not clearly explain the evidentiary standards used to justify NQTLs. This lack of clarity makes it difficult for those evaluating the data to determine if NQTLs are being applied in a fair and nondiscriminatory manner.

Comparative analysis and parity compliance:

- While insurers generally assert that NQTLs are applied equally to both behavioral health/substance use disorder and medical/surgical benefits, there is often insufficient evidence to back up these claims. The absence of detailed comparative analyses raises concerns about potential disparities in care.
- A major challenge in achieving parity is the inconsistency in how insurers categorize and report NQTLs. This variability complicates efforts to compare the application of NQTLs across different insurers and benefit types.
- There is a growing awareness of the need for more consistent practices in how NQTLs are applied and reported. The division is increasingly focused on ensuring that insurers provide clear, detailed, and comparable data to support compliance with parity requirements.

Findings – claims, telehealth, denials, and provider rates

Claims

Under Oregon HB 3046 (2021), insurers are required to report detailed information regarding the payment of claims for both behavioral health and medical/surgical services. This reporting includes:

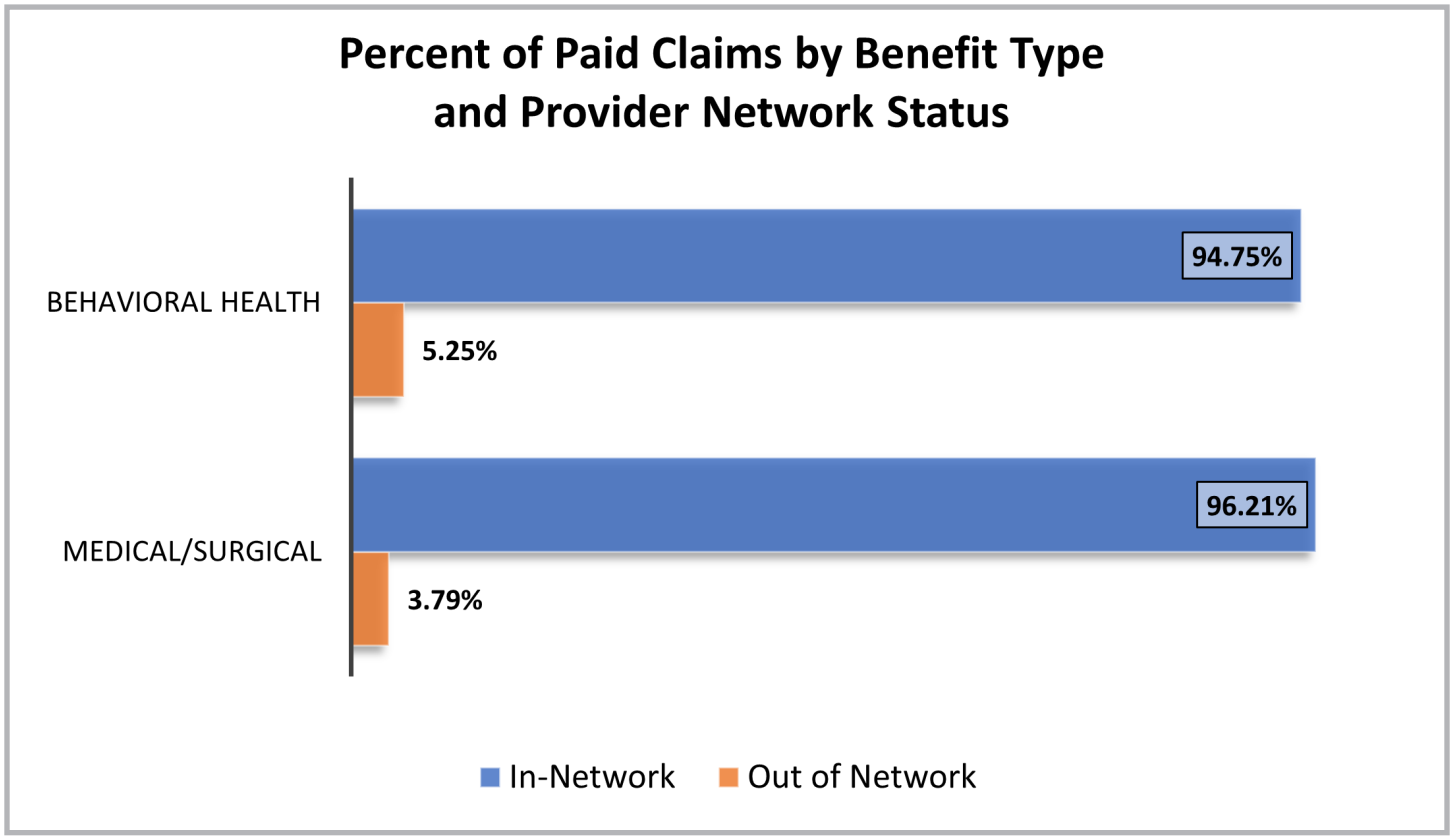
- The percentage of claims paid to in-network providers versus out-of-network providers.
- Trends over time in the utilization of in-network and out-of-network providers.
- Variations among insurers in terms of total claim volume.

The information collected aims to provide insights into the network utilization patterns of insurers and highlight trends toward increased use of in-network providers, which can affect cost, access, and quality of care.

Key findings

Data submitted by insurers reveals significant findings regarding the payment of claims for behavioral health services. In 2023, 94.75 percent of behavioral health claims were paid to in-network providers, leaving 5.25 percent paid to out-of-network providers. In comparison, medical/surgical services showed an even higher percentage of claims paid to in-network providers, at 96.21 percent, with 3.79 percent going to out-of-network providers. It is important to note that while insurers have a role in maintaining provider networks, some out-of-network claims may result from consumer choice, as individuals may opt to seek care outside of the network.

Figure 3: Percent of paid claims by benefit type and provider network status



Trend over time

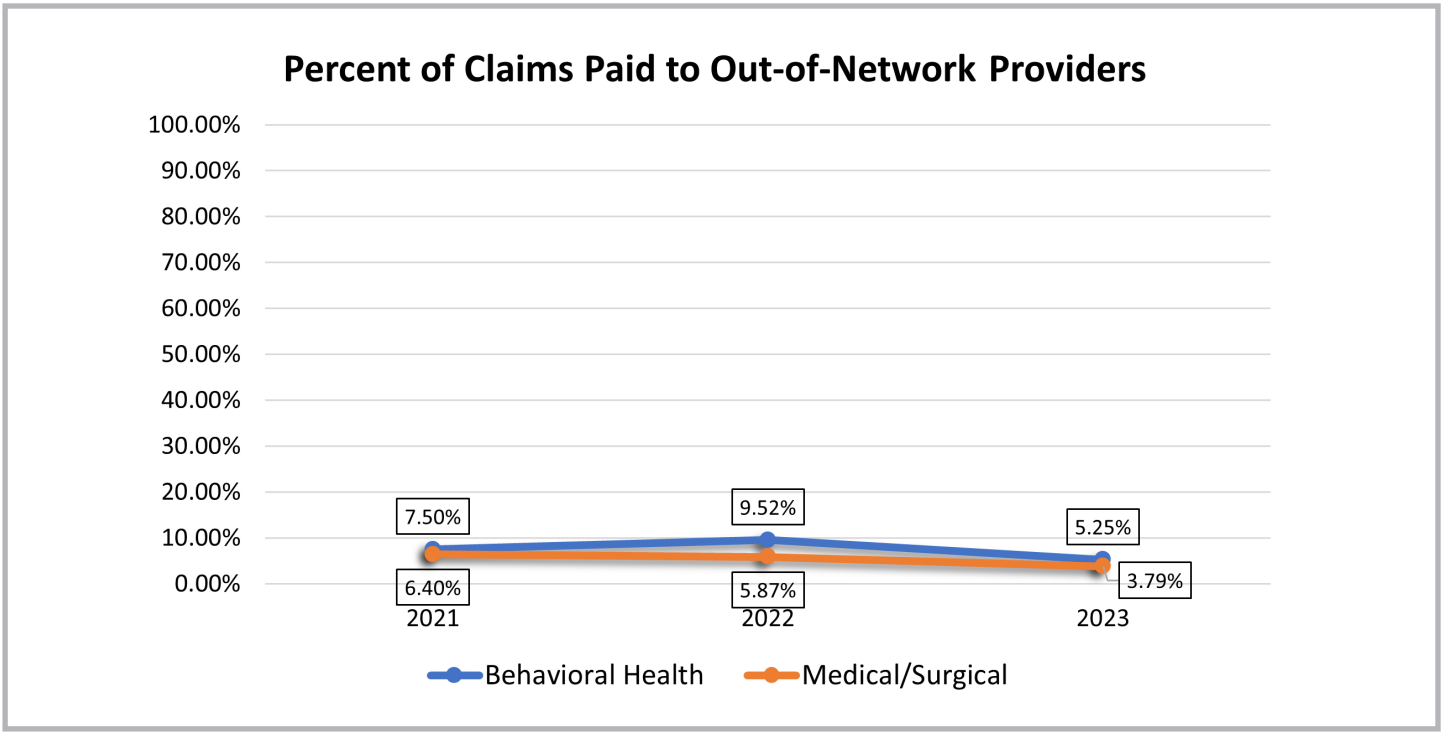
Over the past three years, a notable trend has emerged in health care claims, showing an increasing shift toward in-network providers for behavioral health and medical/surgical services.

In 2021, 92.50 percent of behavioral health claims were paid to in-network providers, while 7.50 percent were paid to out-of-network providers. The following year, in 2022, saw a slight decline in in-network claims to 90.48 percent, with out-of-network claims rising to 9.52 percent. However, by 2023, the trend reversed positively, with in-network claims climbing to 94.75 percent and out-of-network claims dropping to 5.25 percent.

Similarly, medical/surgical services consistently maintained a higher percentage of in-network claims compared to behavioral health services. In 2021, 93.60 percent of medical/surgical claims were in-network, with 6.40 percent out-of-network. This percentage increased slightly in 2022, with 94.13 percent of claims being in-network and 5.87 percent out-of-network. By 2023, the percentage of in-network claims for medical/surgical services further increased to 96.21 percent, with out-of-network claims decreasing to 3.79 percent.

The year 2023 marked a notable improvement in the percentage of in-network claims for behavioral health and medical/surgical services compared to previous years. Behavioral health in-network claims increased from 90.48 percent in 2022 to 94.75 percent in 2023. Similarly, medical/surgical in-network claims rose from 94.13 percent in 2022 to 96.21 percent in 2023. The gap between behavioral health and medical/surgical in-network claims narrowed in 2023, with only a 1.46 percentage point difference (96.21 percent for medical/surgical versus 94.75 percent for behavioral health). This represents progress toward parity between the two types of services. Figure 4 illustrates the percentage of claims paid to in-network providers for both behavioral health and medical/surgical services from 2021 to 2023. Conversely, Figure 5 presents the percentage of claims paid to out-of-network providers for behavioral health and medical/surgical services during the same period.

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



Telehealth

Under Oregon HB 3046 (2021), insurers are required to report detailed information regarding telehealth services. This reporting includes:

- The total number of telehealth claims for behavioral health and medical/surgical services.
- Any additional relevant information related to telehealth claims.

The information collected aims to provide insights into the utilization of telehealth services across different types of health care. It seeks to highlight trends, variability in adoption rates among insurers, and the overall impact of telehealth on access to care.

Key findings

In 2023, the data reveal a substantial reliance on telehealth for behavioral health services:

- **Behavioral health**: Out of 1,456,528 total claims with payment, 999,556 were telehealth claims, representing 68.63 percent of all behavioral health claims.
- **Medical/surgical**: Out of 5,017,751 total claims with payment, only 311,446 were telehealth claims, accounting for 6.21 percent of all medical/surgical claims.

Variability in telehealth claims by benefit type

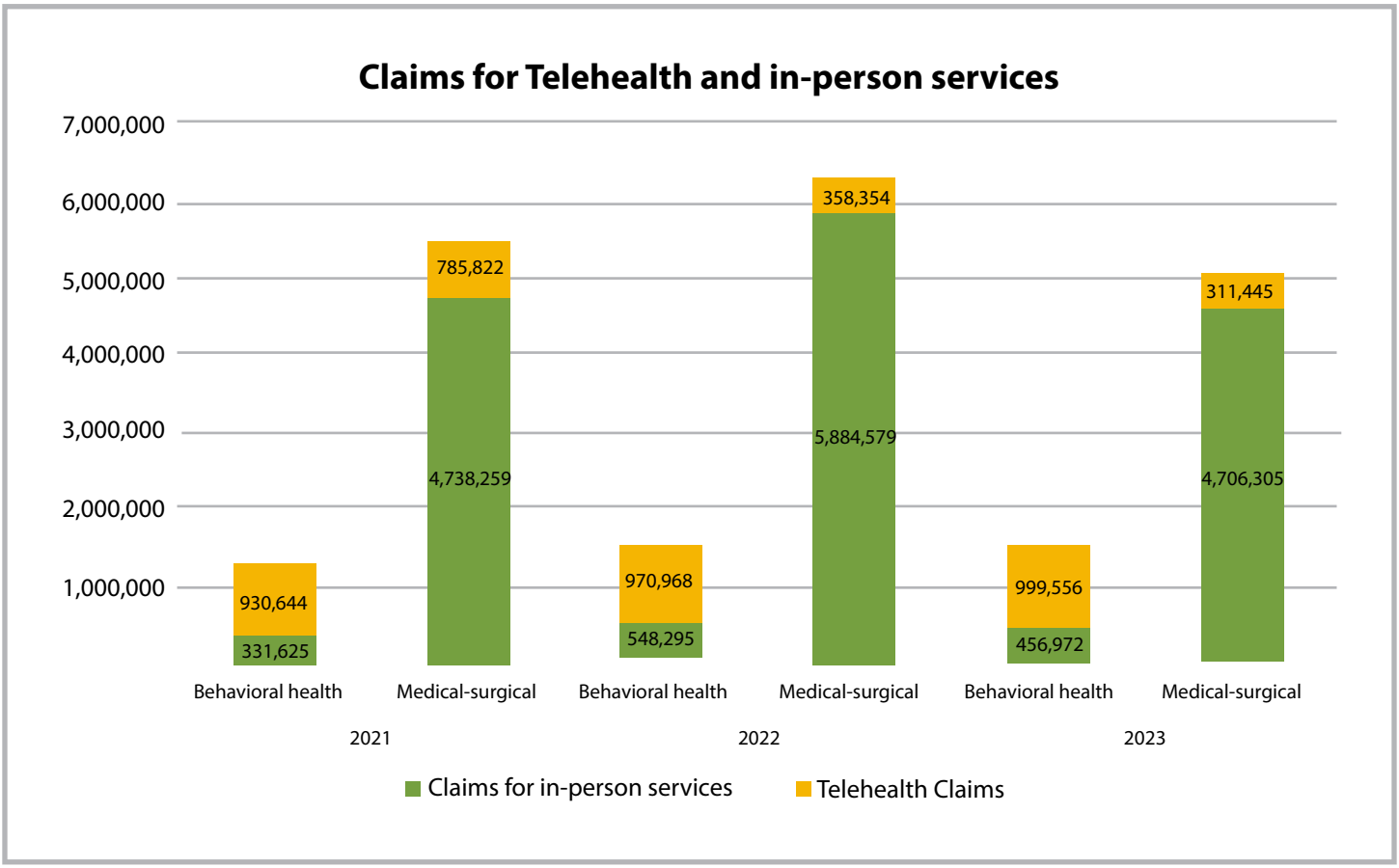
- **Behavioral health**: In 2023, the percentage of total claims that were telehealth-based for behavioral health services varied significantly across insurers. For example, the highest proportion of telehealth claims for behavioral health services was 43 percent, while the lowest (excluding outliers) was 26 percent. This indicates a broad range in the adoption of telehealth for behavioral health services among insurers, with some integrating it more extensively than others.
- **Medical/Surgical**: In 2023, the percentage of telehealth claims for medical/surgical services also showed significant variability across insurers. For example, while one insurer reported 9.6 percent of their total claims as telehealth, others reported much lower percentages. This suggests that while there is variability in the raw numbers, the percentage of claims that are telehealth-based shows more consistency across insurers when viewed proportionally, indicating varying but not extreme differences in telehealth integration.

Trend over time

Examining the trends from 2021 to 2023 provides a clearer picture of the evolving role of telehealth:

- **2021**: There were 1,176,466 telehealth claims out of a total of 6,786,350 claims across all benefit types. Behavioral health telehealth claims (930,644) significantly outnumbered medical/surgical telehealth claims (785,822).
- **2022**: Total claims increased to 7,772,196, with telehealth claims at 1,339,332. Behavioral health telehealth claims remained high at 970,968, while medical/surgical telehealth claims were 368,354.
- **2023**: The total number of claims decreased slightly to 6,474,279, with 1,311,002 telehealth claims. Behavioral health telehealth claims increased to 999,556, whereas medical/surgical telehealth claims further declined to 311,446.

Figure 6: Total claims for telehealth and in-person services from 2021 through 2023



The data highlights significant variability in the adoption and utilization of telehealth across different insurers and benefit types. Behavioral health services show a strong and growing reliance on telehealth, while medical/surgical services have a mixed trend with a generally slower adoption rate. This trend underscores the importance of telehealth in expanding access to behavioral health services and suggests a need for continued support and investment in telehealth infrastructure.

Denials

Under Oregon HB 3046 (2021), insurers are required to report detailed information on denials and appeals for behavioral health and medical/surgical services. This includes:

- The total number of denials.
- The number of appeals of those denials submitted.
- The percentage of denials that are appealed.
- The percentage of appeals that overturned the denial.

This data helps to provide insights into the challenges patients face in getting claims approved and the effectiveness of the appeals process.

Key findings

In 2023, the data reveals notable findings regarding denials and appeals:

- **Behavioral health**: There were 98,877 denials, with 450 appeals. This represents 0.46 percent of denied services being appealed, with 28.44 percent of those appeals being overturned.
- **Medical/surgical**: There were 1,098,874 denials, with 19,522 appeals. This represents

1.78 percent of denied claims being appealed, with 31.04 percent of those appeals being overturned.

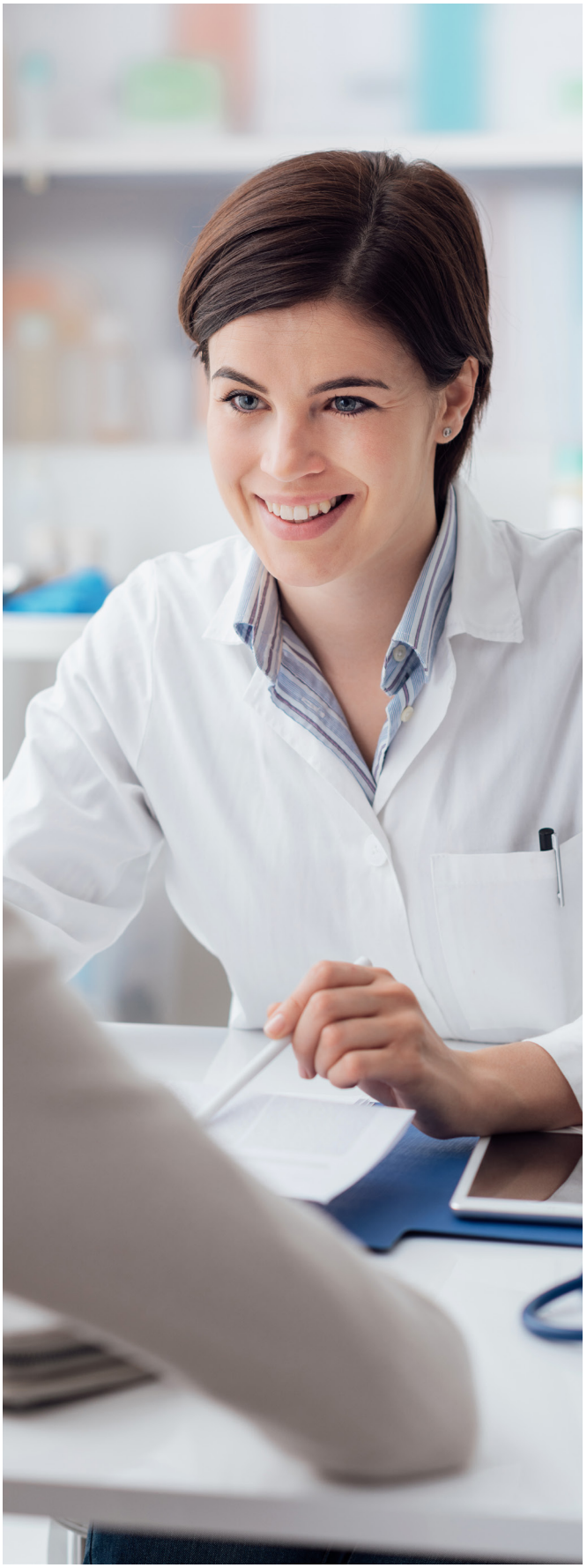
Additionally, the percentage of denials for behavioral health services among different insurers varied significantly, ranging from 0.00 percent to 10.00 percent. For medical/surgical services, the denial rates ranged from 0.00 percent to 9.34 percent.

Trends over time

Examining the trends from 2021 to 2023 provides a clearer picture of the changes in denials and appeals:

- **2021**: There were 114,323 denials for behavioral health and 391,876 for medical/surgical services. Of these denials, 0.52 percent of behavioral health denials and 2.69 percent of medical/surgical denials were appealed. The overturn rates for these appeals were 31.14 percent for behavioral health and 35.34 percent for medical/surgical.
- **2022**: Behavioral health denials decreased to 100,124, while medical/surgical denials increased to 782,096. Appeals dropped to 0.25 percent for behavioral health and 1.17 percent for medical/surgical. The overturn rates were 25.70 percent for behavioral health and 36.61 percent for medical/surgical.
- **2023**: We are still working with insurers to determine the accuracy of the data for 2023, and further analysis will be provided once the validation process is complete.

The data from 2021 and 2022 highlights a significant difference in appeal rates between behavioral health and medical/surgical denials, with a consistently higher appeal rate for medical/surgical services. The fluctuation in overturn rates across both categories suggests variability in the appeals process, emphasizing the need for ongoing monitoring and evaluation of these trends.



Provider reimbursement rates

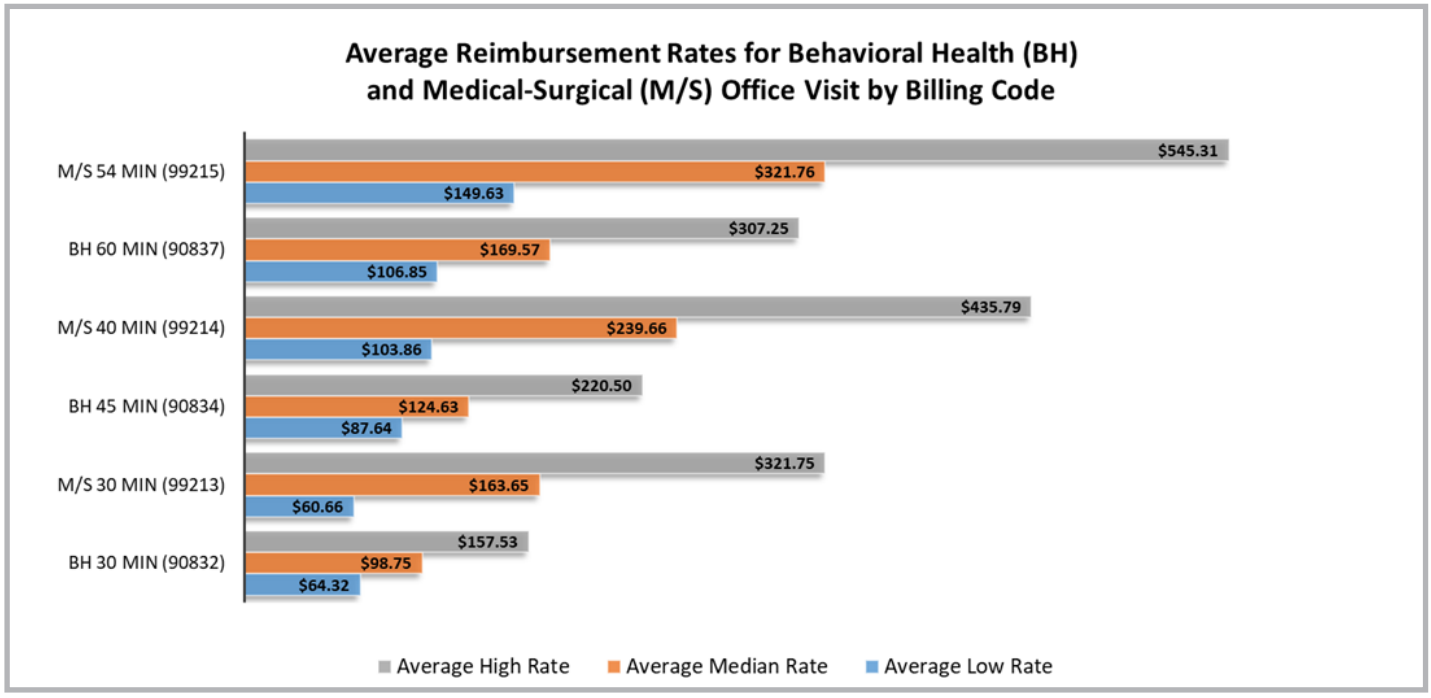
Insurers reported information on provider rates as the median maximum allowable rate for incurred claims during 2023. The applicable Oregon Administrative Rule defines the median maximum allowable rate as "the median of all maximum allowable reimbursement rates, minus incentive payments."[8] These rates were reported in several forms by CPT codes listed on the division's website.[9] Provider rates were submitted by CPT code and provider type for in-network, 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 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.[10] The framework provides reference CPT codes for conducting this comparative analysis using CPT codes related to office visits for both behavioral health and medical/surgical providers.

Figure 7 provides the average median, low, and high in-network reimbursement rates for specified related office visit CPT codes for both behavioral health and medical/surgical office visits. These rates are averaged between all companies to compare the average reimbursement rates at a market level.

Figure 7: Average in-network reimbursement rates for behavioral health and medical/surgical office visit by CPT code



[8] OAR 836-053-1425(4).
[9] Oregon Division of Financial Regulation. "*HB 3046 Annual Reporting CPT Code List*". Accessed, August 2024.
[10] Department of Labor. "*Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*." Accessed, August 2024.

Figure 8:

Difference in comparative time-based visits for medical/surgical (M/S) and behavioral health (BH) (median rate)		
M/S 54 mins. to BH 60 mins.	M/S 40 mins. to BH 45 mins.	M/S 30 mins. to BH 30 mins.
$119.44	$91.25	54.97

Figure 8 provides the average difference in comparative time-based office visits for all six comparable CPT codes detailed in Figure 7.

Figures 9 and 10 provide a visualization of year-to-year average median rate of reimbursement change for a 30-minute behavioral health office visit (CPT 90832) for in-network behavioral health providers; and the average median rate of reimbursement change for a 30-minute medical/surgical office visit (CPT 99213) for in-network medical/surgical providers. From 2022 to 2023, the average median in-network reimbursement rate increased for both behavioral health and medical/surgical providers; however, the increase for behavioral health providers was approximately $5.31 less than the medical/surgical providers increase.

Figure 9: Average of median rate of reimbursement to in-network behavioral health providers billing CPT code 90832

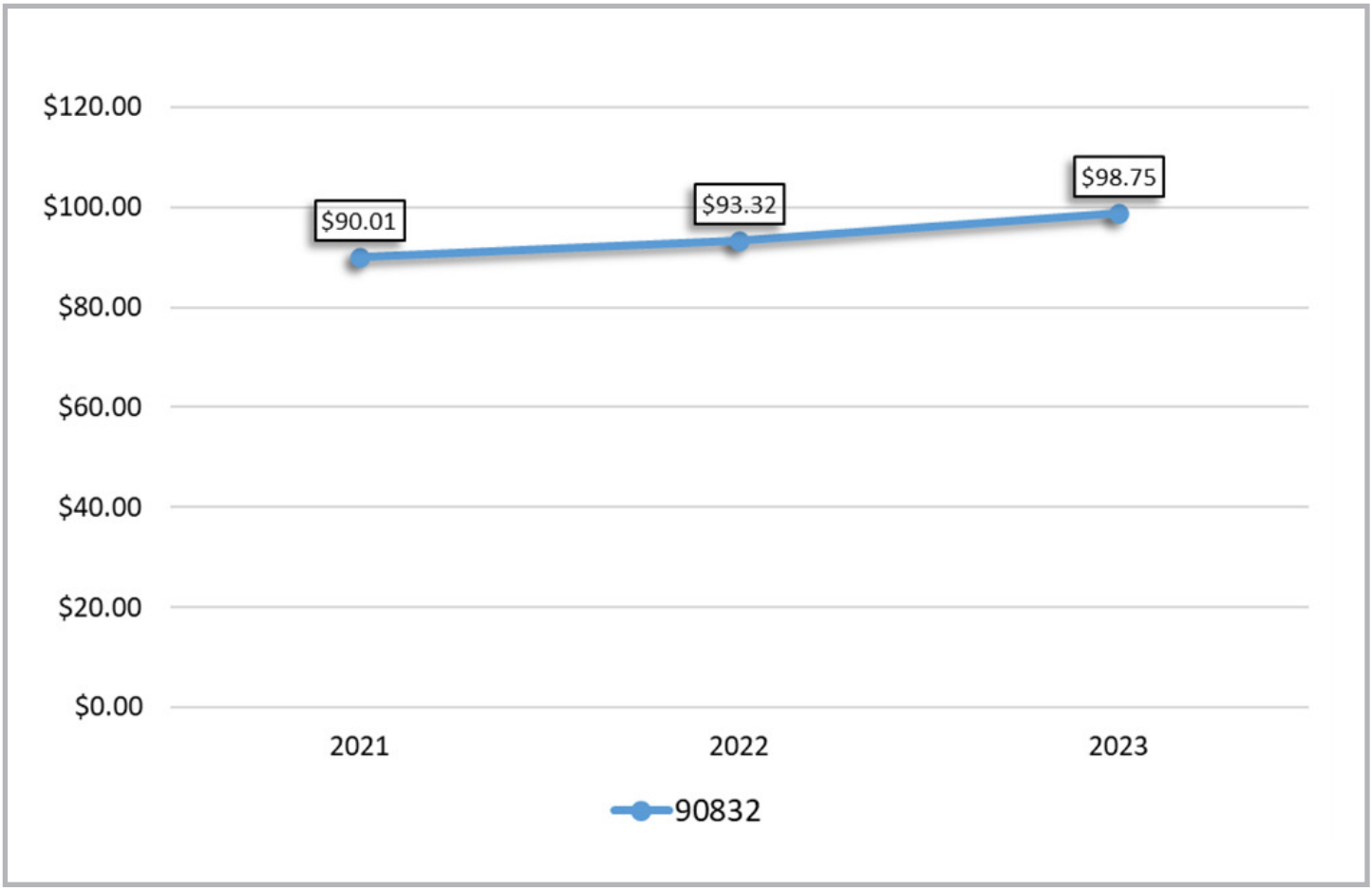
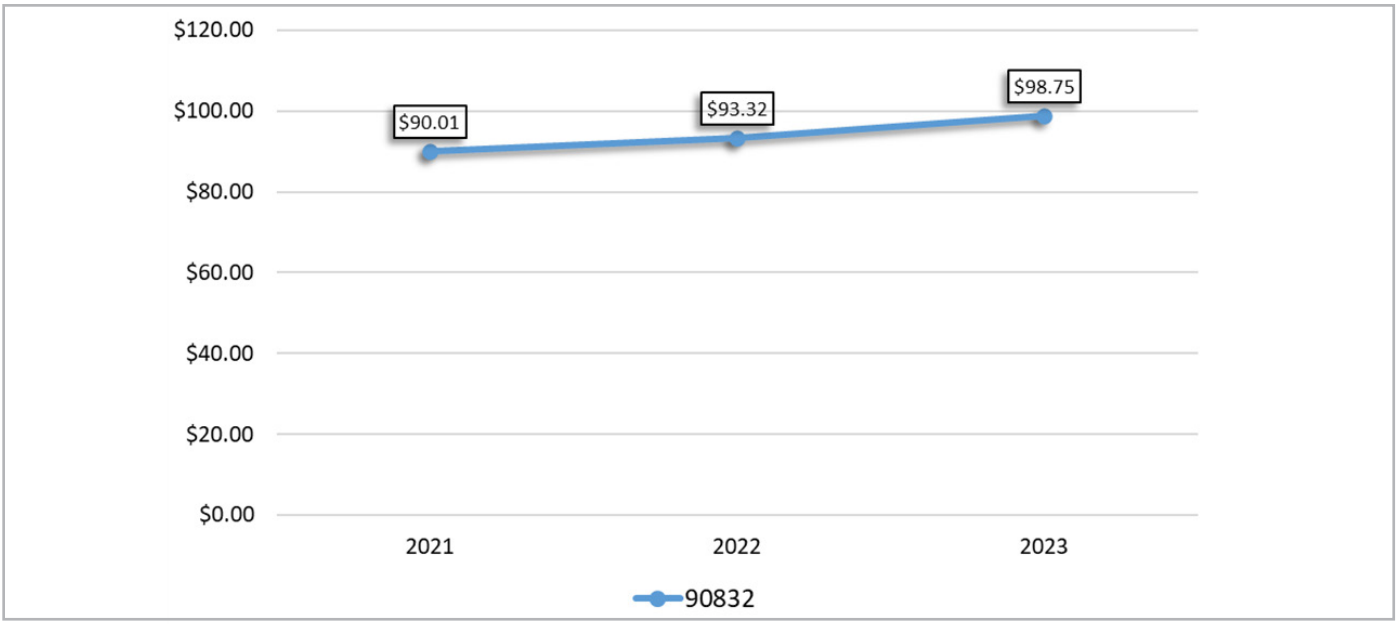


Figure 10: Average median rate of reimbursement to in-network medical/surgical providers billing CPT Code 99213



Average median reimbursement rates were reported by provider type as another way to analyze parity. Figure 11 displays these reimbursement rates for several different types of providers. The 2023 reimbursement rate data reported by insurers for "Average of median in-network reimbursement rates for BH (behavioral health) and M/S (medical/surgical) office visit CPT codes by provider type" is labeled as not-applicable for certain office visit CPT codes that do not pertain to either the behavioral health or medical/surgical provider.

Figure 11: Average of median in-network reimbursement rates for behavioral health and medical/surgical office visit CPT codes by provider type.

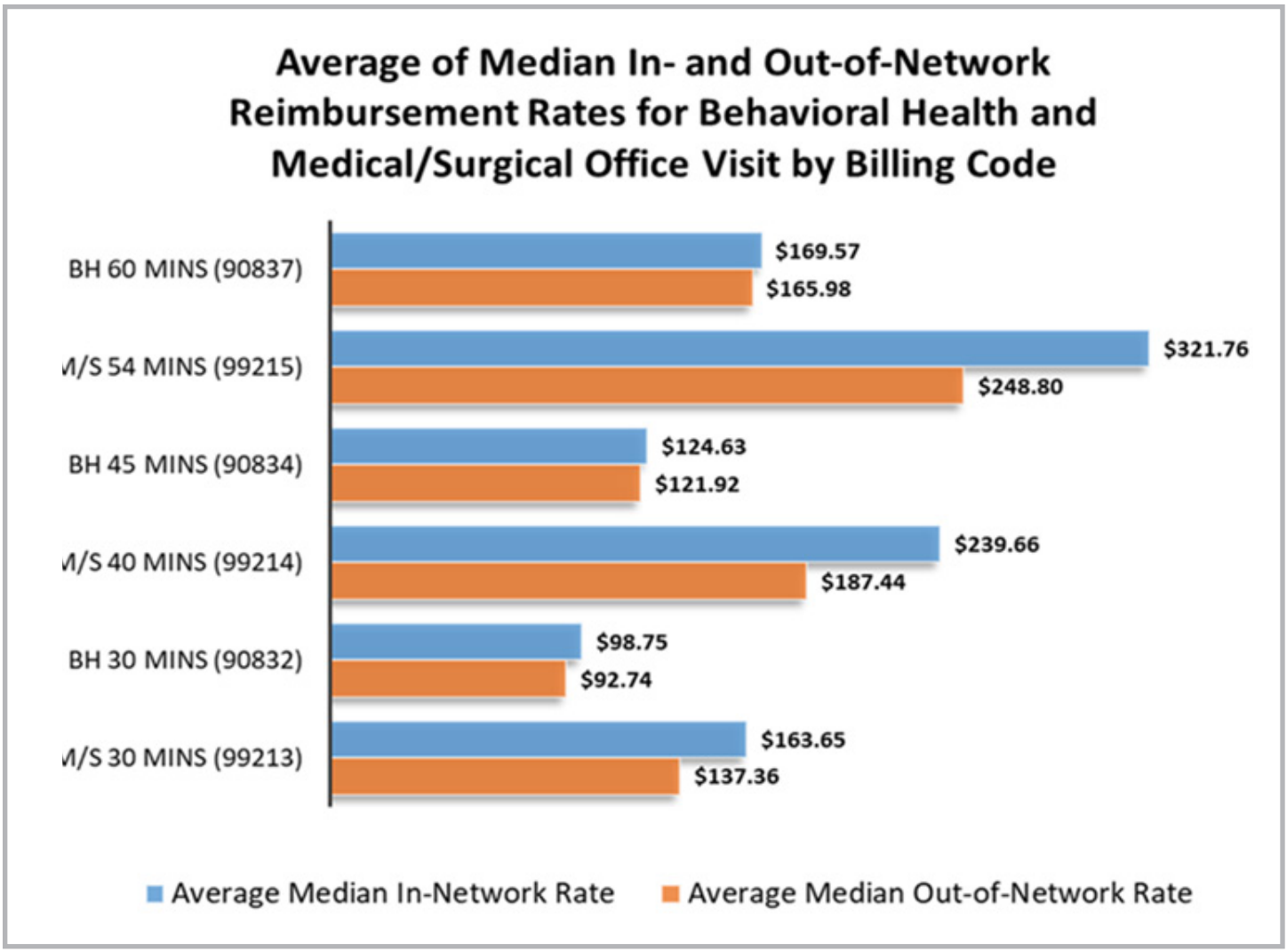
	Behavioral Health - Psychotherapy Office Visit			Medical/Surgical Office Visit		
Provider Type	30 min. (90832)	45 min. (90834)	60 min. (90837)	30 min. (99213)	40 min. (99214)	54 min. (99215)
Licensed Clinical Social Workers	$84.06	$109.62	$109.62	N/A	N/A	N/A
Licensed Marriage and Family Therapists	$81.00	$104.71	$104.71	N/A	N/A	N/A
Licensed Nurse Practitioners	N/A	N/A	N/A	$149.80	$214.21	$294.85
Licensed Professional Counselors	$76.99	$105.23	$105.23	N/A	N/A	N/A
Physician Assistants	N/A	N/A	N/A	$151.90	$207.41	$273.63
Physicians	N/A	N/A	N/A	$145.62	$217.20	$292.18
Psychiatric Mental Health Nurse Practitioners	$104.48	$152.56	$152.56	N/A	N/A	N/A
Psychiatrists	$117.34	$145.44	$145.44	N/A	N/A	N/A
Psychologists	$117.93	$134.79	$134.79	N/A	N/A	N/A
Registered Interns	$101.25	$128.40	$128.40	$214.15	$273.79	N/A

For all provider types, the average of median reimbursement rates for medical/surgical office visit CPT codes are higher than behavioral health office visit CPT codes. Insurer narrative reports have identified factors that affect provider reimbursement rates regardless of whether a behavioral health or medical/surgical provider:

- 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 or specialty.
    - Provider's market position .
    - The number of providers of a particular provider type in the geographic market.
    - Network need or demand for provider type or specialty (e.g., languages spoken or 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 ("CPI").
    - Claims data.

Insurer narrative reports have 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 company is seeking to contract with the provider. The division has used comparable CPT office visit codes for the purpose of its comparative analysis. The division will continue to engage with providers and insurers to determine if there are more appropriate codes to be considered for behavioral health parity comparisons.

Figure 12: Average of median in-network and out-of-network reimbursement rates for behavioral health and medical/surgical office visit by CPT.



Out-of-network

Insurers reported on the average of median out-of-network reimbursement rates for the same office visit CPT codes and provider types. Figure 12 illustrates the reported average of median out-of-network reimbursement rates for comparable behavioral health and medical/surgical office visit CPT codes were lower than in-network rates.

Out-of-network reimbursement rates were also reported by provider type. For most providers out-of-network reimbursement rates for a 30-minute behavioral health or medical/surgical office visit are lower than in-network reimbursement rates.

Figures 13 and 14 provide a visualization of the year-to-year average of median rate of reimbursement changes for a 30-minute behavioral health office visit (CPT 90832) to out-of-network behavioral health providers; and average of median rate of reimbursement changes for 30-minute medical/surgical office visit (CPT 99213) to out-of-network medical/surgical providers. From 2022 to 2023, the average median out-of-network reimbursement rate increased for both behavioral health and medical/surgical providers; however, the increase for behavioral health providers was approximately $8.04 less than the medical/surgical providers increase.

Figure 13: Average of median rate of reimbursement to out-of-network behavioral health providers billing for a 30-minute behavioral health office visit CPT 90832

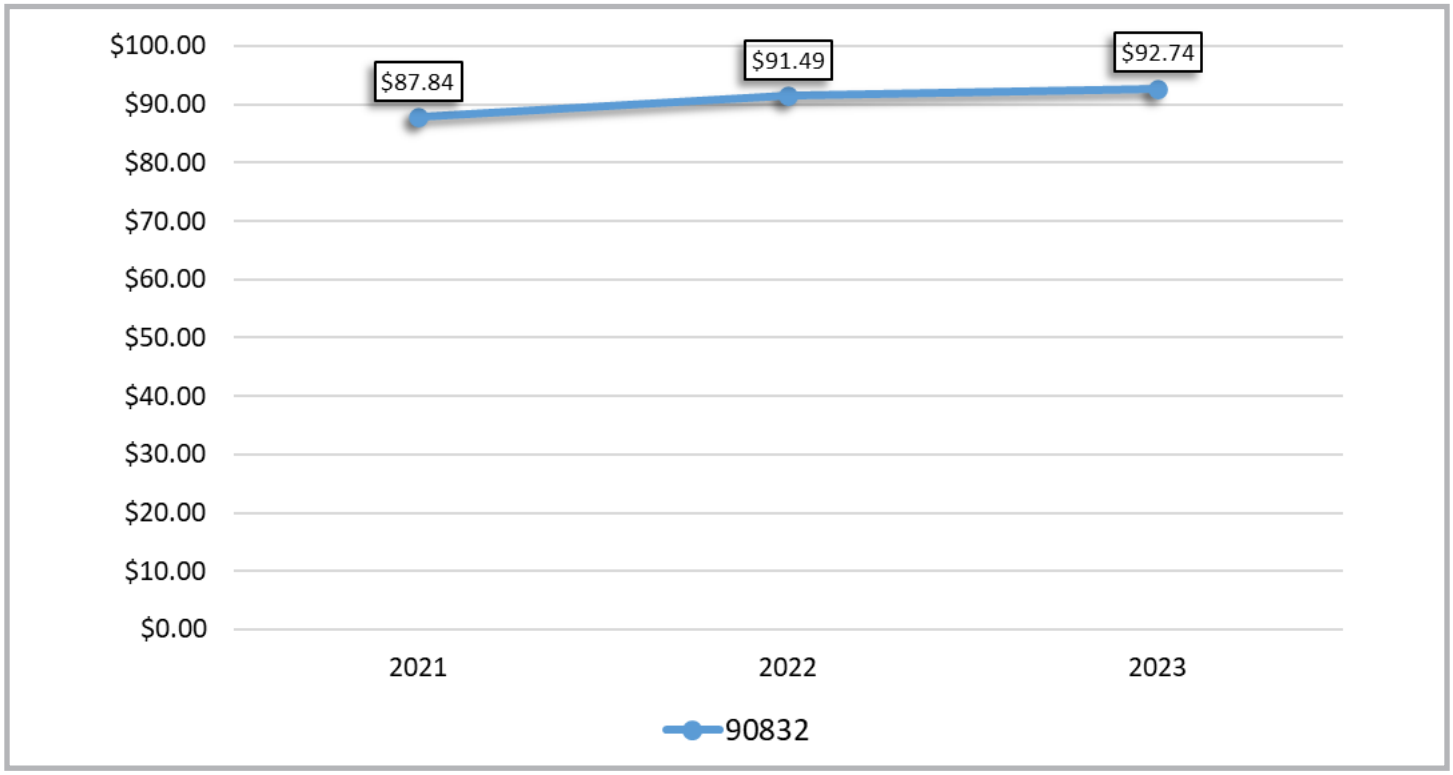
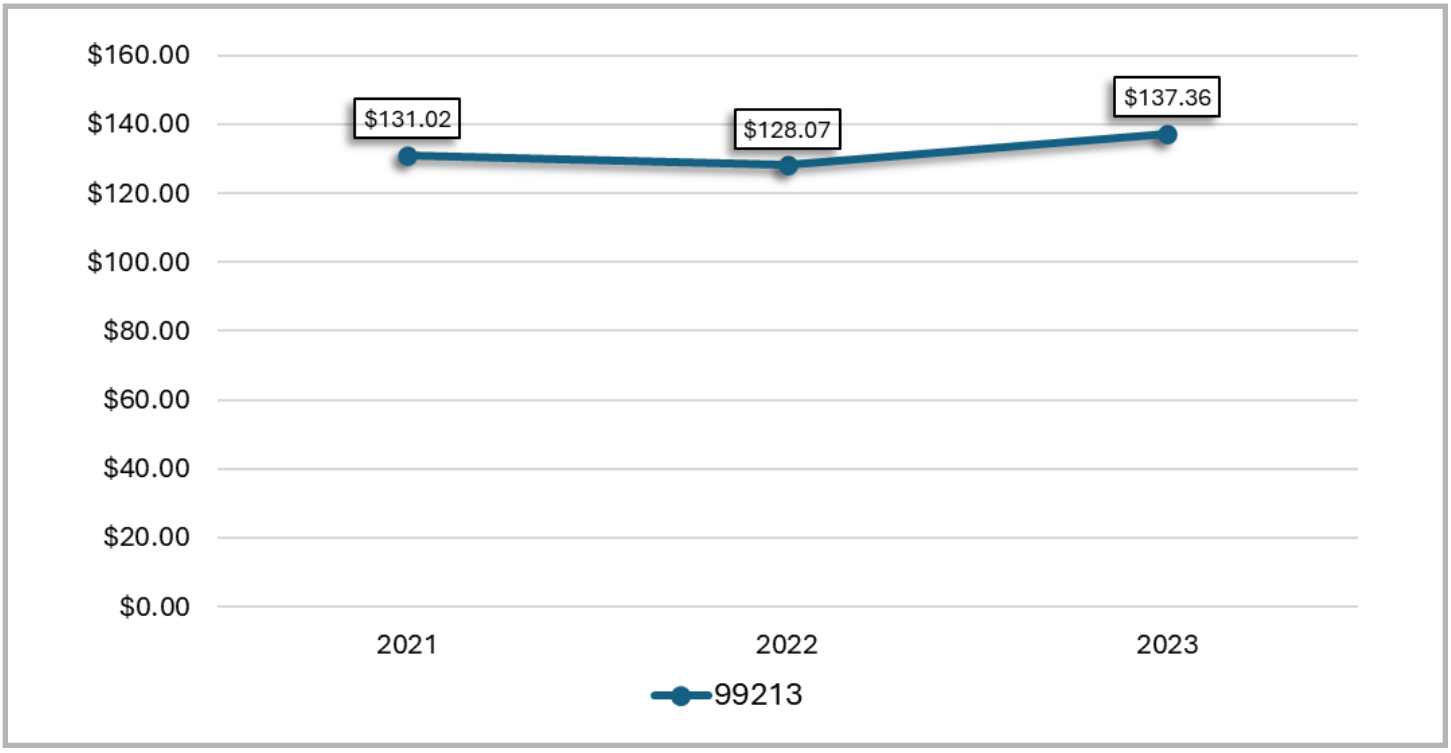


Figure 14: Average median rate of reimbursement to out-of-network medical/surgical providers billing for a 30-minute medical/surgical office visit CPT 99213

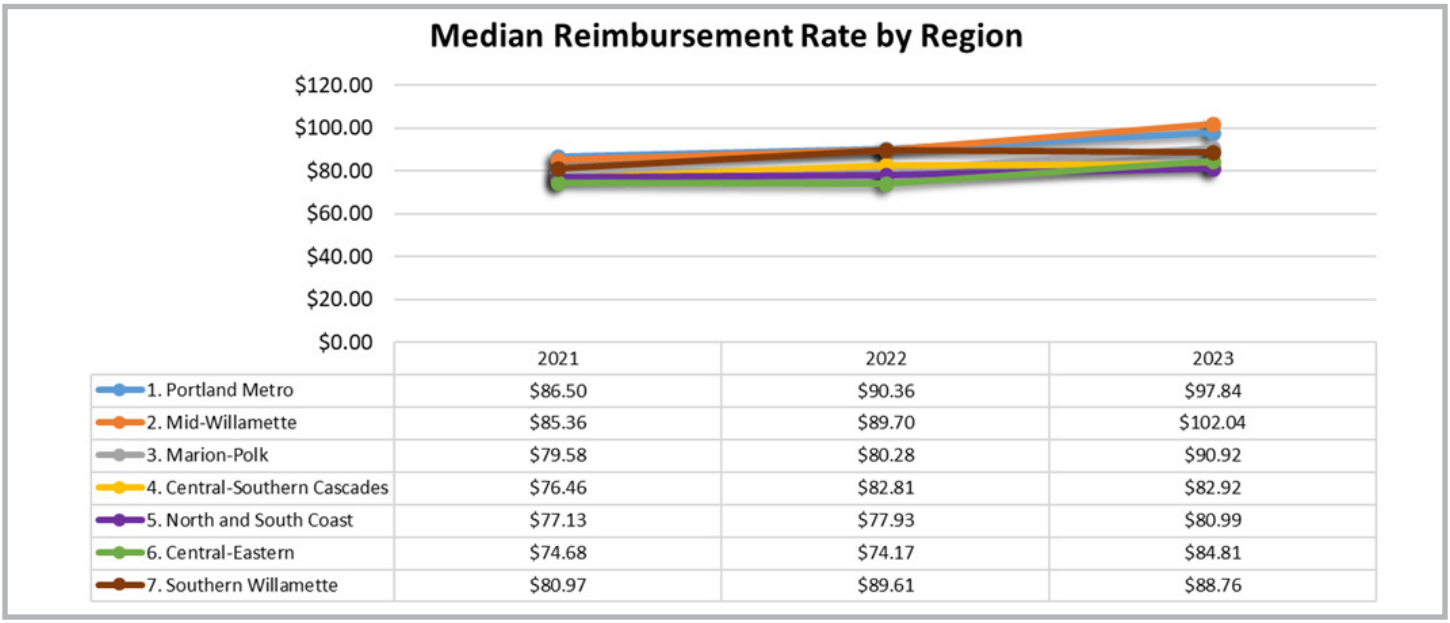


Geographic rate

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.[11]

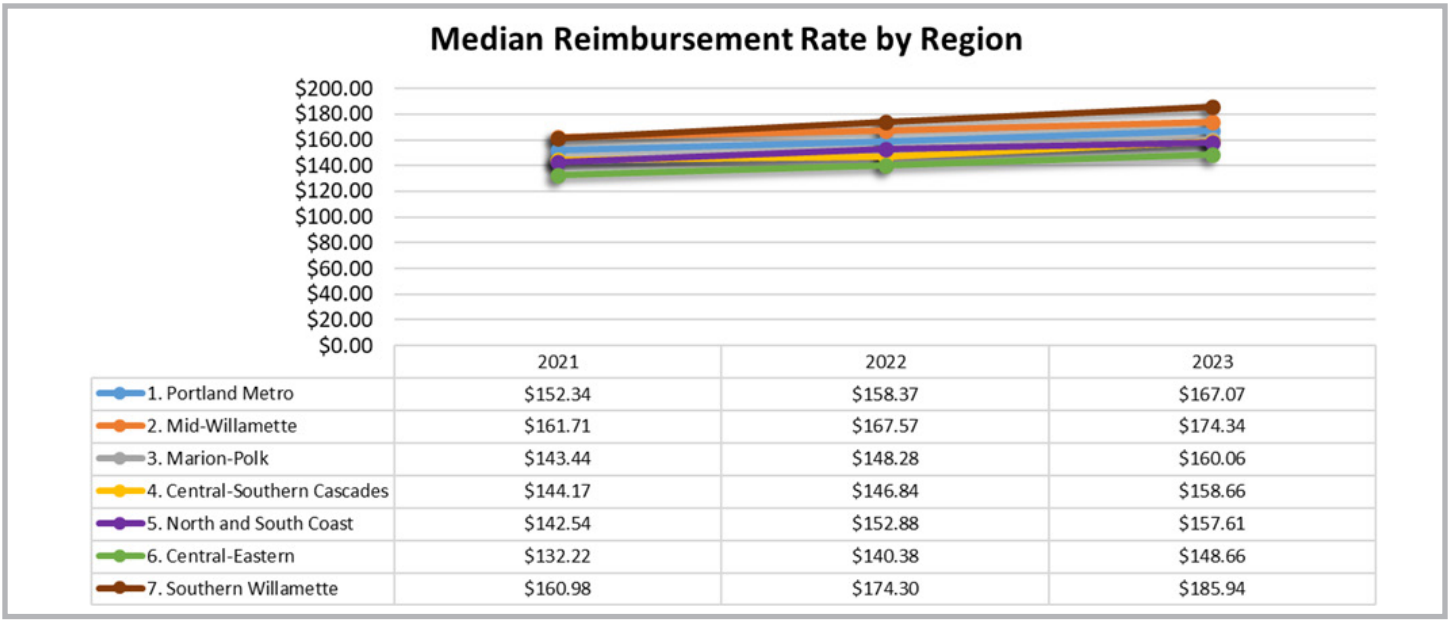
Figure 15 and 16 provide a year-to-year comparison of the median reimbursement rate by region for a 30-minute behavioral health office visit (CPT 90832) and a 30-minute medical/surgical office visit (CPT 99213). All regions had increases for 30-minute behavioral health office visit (CPT 90832) from 2022 to 2023, except for a slight decrease in region No. 7 (Southern Willamette). All regions had increases for a 30-minute medical/surgical office visit (CPT 99213).

Figure 15: Median reimbursement rate by region for a 30-minute behavioral health office visit CPT 90832



	2021	2022	2023
1. Portland Metro	$86.50	$90.36	$97.84
2. Mid-Willamette	$85.36	$89.70	$102.04
3. Marion-Polk	$79.58	$80.28	$90.92
4. Central-Southern Cascades	$76.46	$82.81	$82.92
5. North and South Coast	$77.13	$77.93	$80.99
6. Central-Eastern	$74.68	$74.17	$84.81
7. Southern Willamette	$80.97	$89.61	$88.76

Figure 16: Median reimbursement rate by region for a 30-minute medical/surgical office visit CPT 99213



	2021	2022	2023
1. Portland Metro	$152.34	$158.37	$167.07
2. Mid-Willamette	$161.71	$167.57	$174.34
3. Marion-Polk	$143.44	$148.28	$160.06
4. Central-Southern Cascades	$144.17	$146.84	$158.66
5. North and South Coast	$142.54	$152.88	$157.61
6. Central-Eastern	$132.22	$140.38	$148.66
7. Southern Willamette	$160.98	$174.30	$185.94

[11] Oregon Division of Financial Regulation. "*Oregon Geographic Rating Areas*". Accessed, August 2024.

Figure 17 displays the average of median reimbursement rates for 30-minute behavioral health or medical/surgical office visits by geographic region compared to the percent of the Medicare reimbursement rate by geographic region. The comparable 30-minute behavioral health and medical/surgical office visit CPT codes are both more than 100 percent of the Medicare reimbursement rate for all seven geographic regions.

Figure 17:

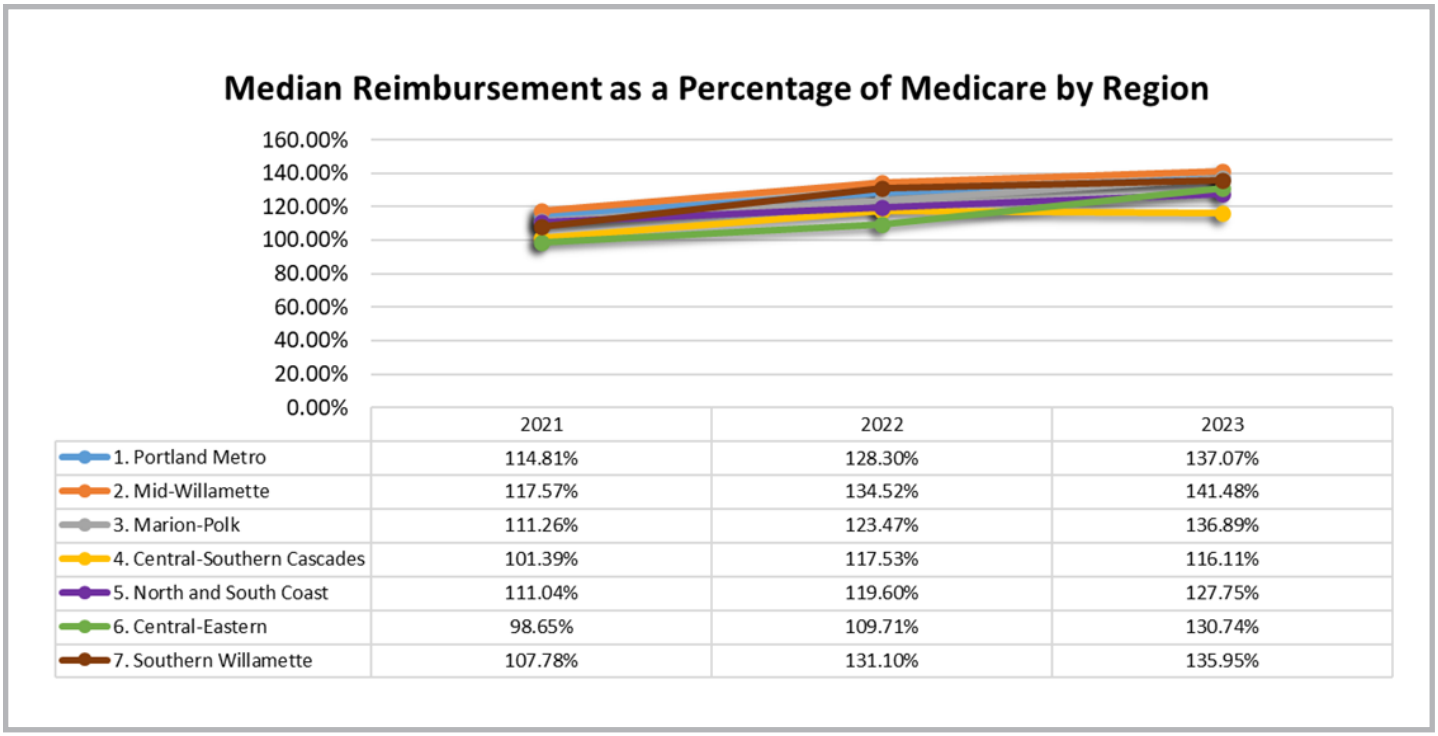
Average of Median Reimbursement Rates for 30-minute Office Visits by Oregon Geographic Region

	BH 30 mins (90832)		M/S 30 mins (99213)	
Geographic Region	Reimbursement Rate	% of Medicare Rate	Reimbursement Rate	% of Medicare Rate
1. Portland Metro	$97.84	137.07%	$154.18	176.98%
2. Mid-Willamette	$102.04	141.48%	$160.21	188.00%
3. Marion-Polk	$90.92	136.89%	$151.98	180.63%
4. Central-Southern Cascades	$82.92	116.11%	$149.21	174.60%
5. North and South Coast	$80.99	127.75%	$142.79	168.14%
6. Central-Eastern	$84.81	130.74%	$139.95	163.90%
7. Southern Willamette	$88.76	135.95%	$163.13	195.02%

Figures 18 and 19 provide a year-to-year rate comparison by geographic region compared to the percent of the Medicare rate. CPT 90832 (30-minute behavioral health office visit) was used for the behavioral health providers' year-to-year comparison. CPT 99213 (30-minute medical/surgical office visit) was used for the medical/surgical providers' year-to-year comparison.

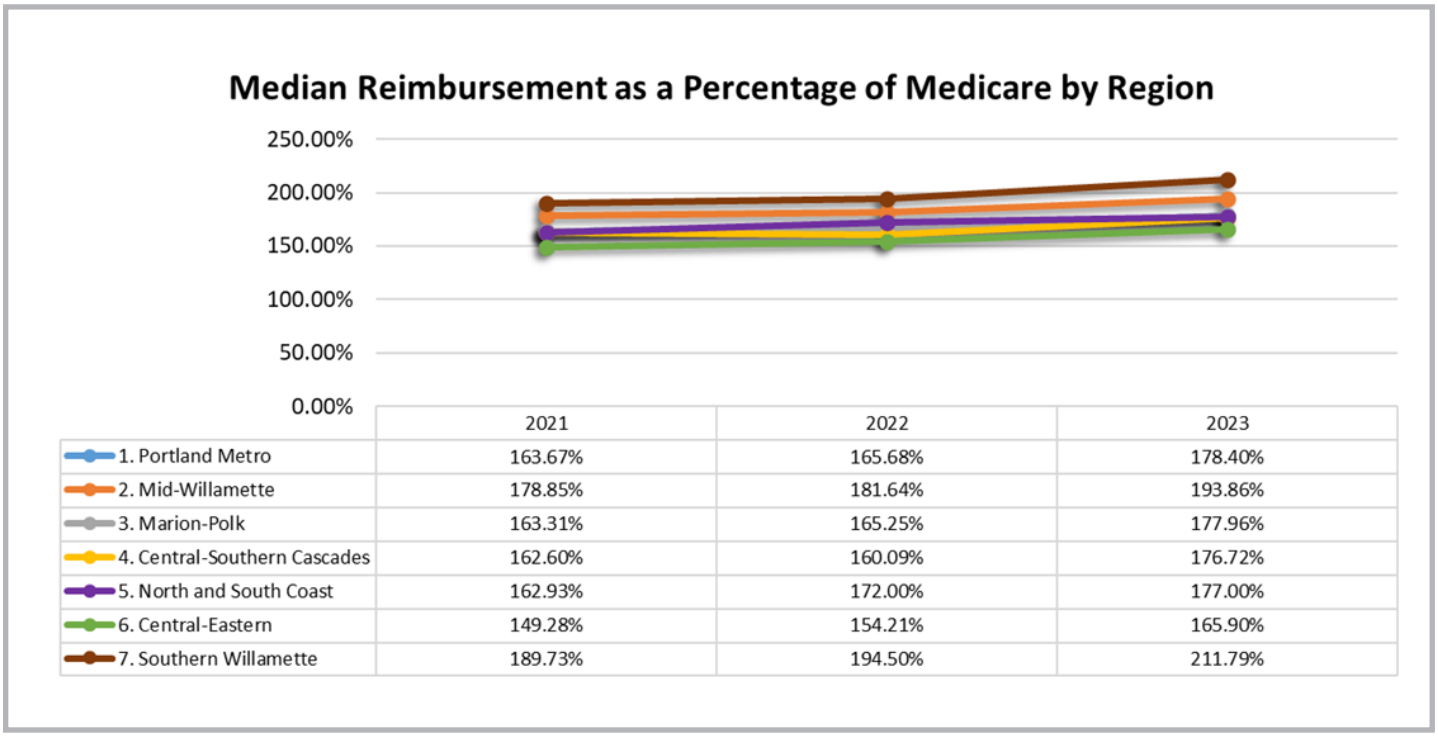
From 2022 to 2023, the median reimbursement rate as a percent of Medicare for a 30-minute behavioral health office visit (CPT 90832) increased for all regions, except for a slight decrease in region No. 4 (Central-Southern Cascades). From 2022 to 2023, the median reimbursement rate as a percent of Medicare for a 30-minute medical/surgical office visit (CPT 99213) increased for all regions.

Figure 18: Median reimbursement as a percent of Medicare by geographical region for a 30-minute behavioral health office visit CPT 90832



	2021	2022	2023
1. Portland Metro	114.81%	128.30%	137.07%
2. Mid-Willamette	117.57%	134.52%	141.48%
3. Marion-Polk	111.26%	123.47%	136.89%
4. Central-Southern Cascades	101.39%	117.53%	116.11%
5. North and South Coast	111.04%	119.60%	127.75%
6. Central-Eastern	98.65%	109.71%	130.74%
7. Southern Willamette	107.78%	131.10%	135.95%

Figure 19: Median reimbursement as a percent of Medicare by geographical region for a 30-minute medical/surgical office visit CPT 99213



	2021	2022	2023
1. Portland Metro	163.67%	165.68%	178.40%
2. Mid-Willamette	178.85%	181.64%	193.86%
3. Marion-Polk	163.31%	165.25%	177.96%
4. Central-Southern Cascades	162.60%	160.09%	176.72%
5. North and South Coast	162.93%	172.00%	177.00%
6. Central-Eastern	149.28%	154.21%	165.90%
7. Southern Willamette	189.73%	194.50%	211.79%

Conclusion

The findings described in this 2024 annual report on 2023 data reported to the Oregon Division of Financial Regulation reveal progress and ongoing challenges in the landscape of behavioral health and medical/surgical service coverage. While insurers are making strides toward complying with federal and state parity laws, significant inconsistencies remain in how NQTLs are applied, particularly between behavioral health/substance use disorder and medical/surgical benefits.

Insurers continue to base their coverage decisions on evidence-based criteria and professional judgment, but there are still notable variations in the application of medical management standards, formulary designs, and provider network adequacy. These disparities are especially evident in behavioral health services, where access and network sufficiency continue to be problematic. The increasing reliance on telehealth services, while beneficial in some ways, raises concerns about the availability of in-person care options.

Issues with transparency in reporting and inconsistencies in the data provided by insurers make it difficult to fully assess whether they are meeting parity requirements. Although there has been progress in narrowing the gap between behavioral health and medical/surgical services – particularly in the use of in-network providers – significant work remains to ensure that true parity is achieved across all aspects of health care.

The data on claims, telehealth usage, denials, and provider reimbursement rates highlight the complexities of the current system. Over time, the trends show a mix of improvements and growing concerns, especially regarding claim denials and the differences in reimbursement rates for in-network versus out-of-network providers.

Overall, these findings emphasize the ongoing need to closely monitor and refine how NQTLs are applied, ensuring that all patients receive fair, equitable, and timely care, regardless of the type of service they need.

Appendix A: Reporting Form for NQTL Analysis

The reporting form for the NQTL data analysis was provided as a Microsoft Word document to each insurer. Access to the reporting form can be found on the DFR behavioral health parity webpage located at https://dfr.oregon.gov/business/reg/health/Documents/mental-health-parity/annual-MHP-reporting-template.xlsx.

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 behavioral health parity webpage located at https://dfr.oregon.gov/business/reg/health/Documents/mental-health-parity/annual-MHP-reporting-template.xlsx.