Report on Behavioral Health Parity

As required by ORS 743B.427

DCBS | Department of Consumer and Business Services

Sept. 15, 2025

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 services 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 2024.

Acknowledgments

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Introduction

Ensuring parity between behavioral health/substance use disorder and medical/surgical services remains a priority in Oregon. This 2025 Behavioral Health Parity Report, prepared by the Department of Consumer and Business Services (DCBS), assesses commercial insurers' compliance with state parity laws, specifically ORS 743A.168. The report emphasizes the implementation and application of nonquantitative treatment limitations (NQTLs) and includes quantitative data derived from the National Association of Insurance Commissioners' Market Conduct Annual Statement data. Findings highlight ongoing challenges in transparency, documentation variability, and consistent application of parity in practice.

Key findings

1. **Nonquantitative treatment limitations (NQTLs):** NQTLs are restrictions on behavioral health/substance use disorder benefits not defined numerically, such as prior authorization requirements, clinical review processes, and provider network admission standards. Significant observations from 2025 include:

- **Policy documentation (as written standard)**: All insurers submitted documentation outlining their NQTL policies, which are used to assess compliance "as written." This standard requires insurers to demonstrate that, on paper, the same processes, evidentiary standards, and factors are applied equally to both behavioral health/substance use disorder and medical/surgical benefits. While all submissions met the basic parity requirement, the quality and level of detail varied considerably across insurers.
- **Operational evidence (in-operation standard)**: The "in operation" standard requires insurers to show how their documented NQTL policies are applied in real-world settings. Many insurers did not provide sufficient comparative evidence or specific examples demonstrating that behavioral health/substance use disorder services are managed in the same manner as medical/surgical services. Gaps in operational data made it difficult to assess consistent application in practice.
- **Medical management practices**: Insurers reported using prior authorization, concurrent review, and step therapy protocols across behavioral health/substance use disorder and medical/surgical services. Several insurers' operational data showed that behavioral health/substance use disorder services were more frequently subject to higher denial rates and required more extensive documentation than comparable medical/surgical services, particularly in the context of prior authorization and utilization review.
- **Formulary management**: Certain insurers applied more restrictive formulary requirements, including higher tier placements and additional prior authorization steps, to behavioral health/substance use disorder medications than comparable medical/surgical medications.

- **Provider networks**: Documentation highlighted continued difficulties in maintaining robust behavioral health/substance use disorder provider networks, with noted administrative differences in credentialing processes and reimbursement practices, particularly affecting nonphysician behavioral health/substance use disorder providers.

2. **Market Conduct Annual Statement (MCAS) data**: Beginning in 2025, certain state-level quantitative reporting requirements expired under existing statute, including requirements for insurers to report denial rates, appeals, and reimbursement data specific to behavioral health/substance use disorder and medical/surgical services. As a result, the primary source of quantitative data available for the 2025 report was the National Association of Insurance Commissioners' Market Conduct Annual Statement (MCAS).

    - According to 2023 MCAS filings, Oregon insurers reported a prior authorization denial rate of 10.2 percent for behavioral health/substance use disorder services, compared to 6.9 percent for medical/surgical services. This trend has remained consistent across the past three reporting years (2021 through 2023). The data also showed that appeals were submitted less frequently for behavioral health/substance use disorder services and had lower overturn rates compared to medical/surgical services.
    - Additional MCAS data showed that the total number of behavioral health/substance use disorder prior authorization requests declined by more than 50 percent between 2021 and 2023. This represents a cumulative decrease over the three-year period rather than a steady annual decline. During the same time frame, the denial rate for behavioral health/substance use disorder prior authorization requests increased by 3.1 percentage points, while the denial rate for medical/surgical services rose by just 0.46 percentage points. Although the total number of prior authorization decisions (approvals and denials combined) remained relatively stable, behavioral health/substance use disorder services continued to experience a higher denial rate relative to the volume of requests when compared to medical/surgical services.

Conclusion

The 2025 report documents progress in insurers' policy-level compliance but emphasizes continued challenges in demonstrating operational parity. DFR's compliance team is working with companies individually to further investigate compliance with ORS 743B.427. Senate Bill 824, enacted in 2025 and effective Jan. 1, 2026, reinstates critical quantitative reporting requirements and establishes confidentiality provisions for insurer-submitted data. These statutory changes are expected to enhance future parity evaluations and improve oversight of behavioral health parity compliance across Oregon's commercial insurance market.

Introduction

This report is prepared in compliance with ORS 743B.427, 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 findings from an analysis of nonquantitative treatment limitations (NQTL) information reported to the department, as well as quantitative data from the Market Conduct Annual Statement (MCAS). The MCAS data is reported annually to the National Association of Insurance Commissioners (NAIC) by insurers offering health benefit plans with behavioral health/substance use disorder coverage in Oregon. The report's purpose is to evaluate insurer compliance with ORS 743A.168 and identify any disparities in coverage between behavioral health/substance use disorder treatments compared to medical/surgical treatments.

Background

Access to behavioral health services remains a significant challenge in Oregon. According to Oregon Health Authority (OHA) reports, the state continues to experience a notable shortage of behavioral health professionals, especially in rural regions of the state. As of 2024, Oregon has 181 identified Health Professional Shortage Areas for behavioral health services, affecting about 1.7 million Oregonians. These shortages are especially acute in rural and frontier counties, where provider density often remains below 10 providers per 100,000 residents.[1]

These workforce shortages are worsened by the high number of individuals experiencing behavioral health and substance use disorder conditions. Recent data from the Oregon Health Plan – Mental Health Parity Report indicates that about 27 percent of adults enrolled in Medicaid in Oregon experienced mental health diagnoses, and 20 percent had a substance use disorder diagnosis in 2023.[2] Similarly, youth behavioral health and substance use disorder needs remain critical, with 24 percent to 38 percent of Oregon high school students reporting depressive symptoms, 21 percent to 35 percent reporting anxiety, and youth involved in state care systems experiencing high rates of mental health (57 percent) and substance use disorder (89 percent) diagnoses.[3]

Network adequacy is another concern, with limited in-network options leading many Oregonians to seek out-of-network care. This often results in significantly higher out-of-pocket costs for individuals, particularly when insurers do not fully reimburse for services provided outside their network. According to the 2024 Behavioral Health Residential Facility Study by OHA, the shortage of adequate treatment facilities contributes to extended wait times and limited treatment options, making disparities worse.[4] Additionally, recent national data indicates that out-of-network utilization for behavioral health services remains significantly higher for medical/surgical services, with Oregonians specifically experiencing heightened disparities in accessing psychiatrists and psychologists out of network. Nationally, behavioral health services have about a 300 percent higher rate of out-of-network use compared to medical/surgical services, with Oregon ranking among the states with the highest disparities.[5]

The ongoing substance use disorder crisis has long strained Oregon's behavioral health infrastructure. However, preliminary data from 2024 offers a hopeful sign: overdose deaths fell by about 22 percent from their peak in 2023, declining from 1,833 deaths (about 44.8 per 100,000 residents) to roughly 1,480 deaths (about 36 per 100,000 residents).[6] This decline marks a significant public health improvement, although the need for additional residential treatment beds remains critical to meeting persistent demand and closing gaps in service availability.

1 Oregon Health Authority, Health Care Workforce Supply Report, 2024. Retrieved from https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/HWRP_Supply_Report_2024.pdf.

2 Oregon Health Authority, Oregon Health Plan Mental Health Parity Report, April 2024. Retrieved from https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2024-MHP-Report0425.pdf.

3 Oregon Health Authority, Oregon Health Plan Mental Health Parity Report, April 2024. Retrieved from https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2024-MHP-Report0425.pdf.

4 Oregon Health Authority, Behavioral Health Residential Facility Study, June 2024. Retrieved from https://www.oregon.gov/oha/HSD/AMH/DataReports/Behavioral-Health-Residential-Facility-Study-June-2024.pdf.

5 Oregon Health Authority, Oregon Health Plan Mental Health Parity Report, April 2024. Retrieved from https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2024-MHP-Report0425.pdf.

6 U.S. Overdose Deaths Decrease Almost 27% in 2024, National Center for Health Statistics (CDC), May 14, 2025. Available at: https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2025/20250514.htm

These persistent challenges underscore the importance of comprehensive monitoring and enforcement of behavioral health parity laws. However, parity alone cannot resolve the broader systemic issues Oregon faces, such as the acute shortage of behavioral health providers, limited treatment capacity, and escalating substance use disorders. While behavioral health systems often face more severe access issues, it is important to acknowledge that similar workforce and network challenges exist on the medical/surgical side as well. Parity ensures comparability in treatment limitations and access standards, but it does not guarantee adequacy if both sides of the equation are strained. Addressing these barriers will require coordinated efforts beyond parity enforcement, including investments in workforce development, expanded treatment infrastructure, and targeted strategies to improve rural access.

Federal legislation

The Mental Health Parity and Addiction Equity Act (MHPAEA), enacted in 2008, established federal requirements for health insurance plans to provide behavioral health and substance use disorder benefits on par with medical/surgical benefits. Under the act, cost sharing, treatment limitations, and coverage restrictions for behavioral health/substance use disorder services must be comparable to those applied to medical/surgical services.[7]

In 2021, federal agencies adopted new compliance provisions to strengthen enforcement of MHPAEA. These measures require insurers to conduct and submit detailed comparative analysis of their coverage, with particular focus on NQTLs, such as prior authorization, step therapy, and provider admission criteria. These requirements were designed to increase transparency and ensure that insurers could demonstrate true parity in how benefits are managed and delivered.[8]

In 2024, the federal government issued final rules further clarifying and strengthening MHPAEA's compliance obligations, particularly around NQTL analysis and comparative documentation.[9] Despite these regulatory changes, the current federal administration announced in 2025 that it would not prioritize enforcement of the 2024 parity rule.[10] As a result, oversight of parity compliance at the federal level has decreased, and states are left to determine their own approaches to monitoring and enforcement of behavioral health parity. This shift has created additional uncertainty and inconsistency in how parity laws are applied across the country.

Oregon legislation

In 2021, the Oregon Legislature passed House Bill 3046, which clarified the requirements for behavioral health parity in commercial health insurance plans and specified rules for the use of NQTLs. Under ORS 743B.427, each insurer offering an individual or group health benefit plan that provides behavioral health benefits must:

- Annually analyze NQTLs as applied to behavioral health/substance use disorder benefits.
- Report to DCBS on the use and application of NQTLs for behavioral health/substance use disorder benefits, as well as for applicable medical/surgical benefits.

The law also requires DCBS to report annually to the legislative assembly by Sept. 15, comparing insurers' coverage of behavioral health/substance use disorder services with coverage of medical/surgical services.

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7 United States Department of Labor. Fact Sheet: The Mental Health Parity Act. Accessed June 18, 2025.

8 2021 Consolidated Appropriations Act, Section 203; Federal Register Notices on MHPAEA Comparative Analyses.

9 Federal Register. "Requirements Related to the Mental Health Parity and Addiction Equity Act." 89 FR 44572, published May 9, 2024.

10 U.S. Department of Labor. *Statement Regarding Enforcement of the Final Rule on Requirements Related to the Mental Health Parity and Addiction Equity Act*. May 15, 2025. Available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea

Beginning in 2025, due to statutory sunset provisions, insurers were no longer required to report certain quantitative data elements, and the department's annual report now focuses primarily on NQTL analysis, with available quantitative data drawn from MCAS filings submitted by insurers to NAIC.

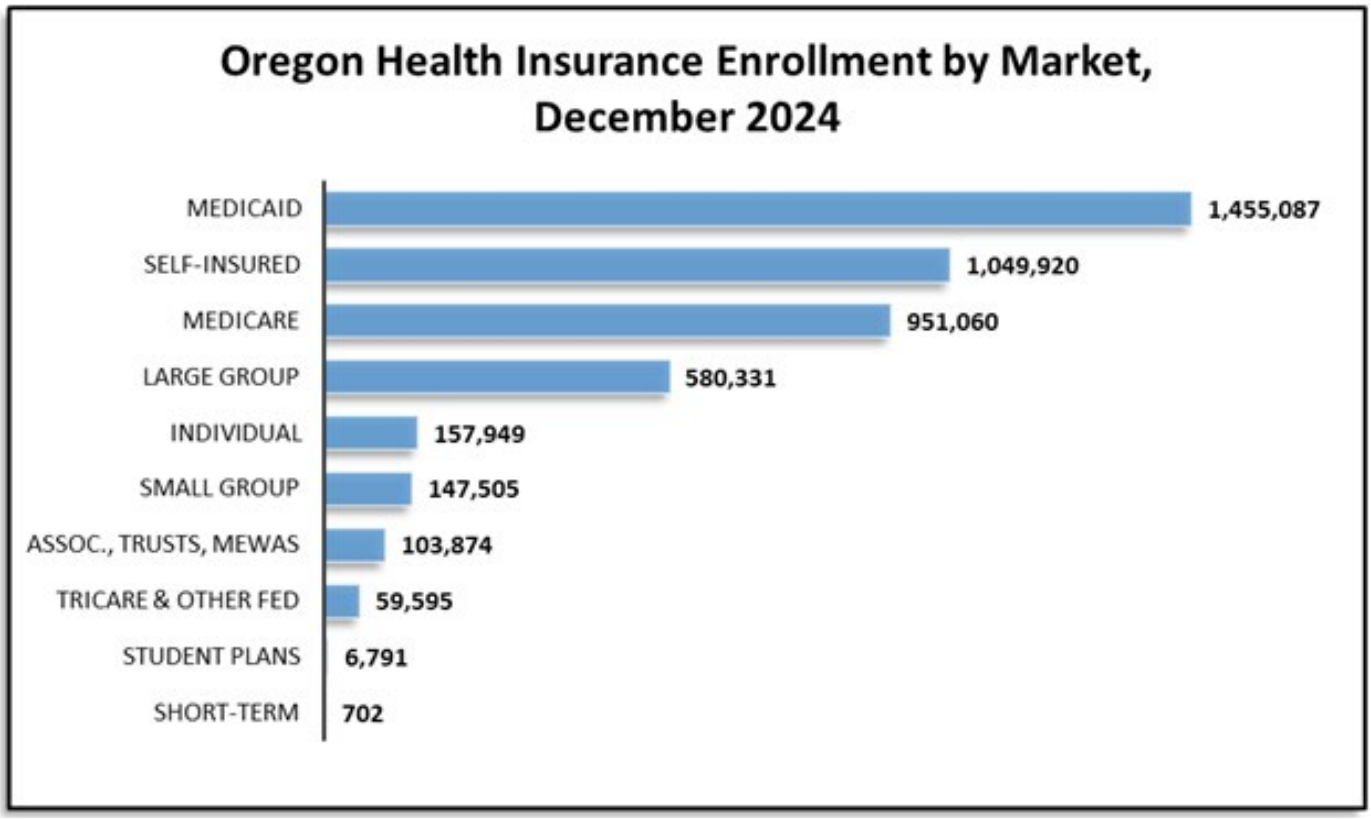
In response to the sunset of these reporting requirements, the department introduced Senate Bill 824 during the 2025 legislative session. The bill was enacted and takes effect Jan. 1, 2026. It reinstates the requirement for insurers to report specific quantitative data metrics, including denial rates, claims payment information, and provider reimbursement rates without a sunset date.[11]

Insurance market and benefits in Oregon

This report focuses on the commercial health insurance market, which is regulated by DCBS. As of December 2024, Oregon's commercial health insurance market included fully insured large group plans, fully insured small group plans, individual health benefit plans, associations, trusts, multiple employer welfare arrangements, and student plans. In total, 996,450 people were enrolled in these DCBS-regulated commercial plans at year-end.

The enrollment numbers shown in Figure 1 represent the number of covered lives by market type, not the number of unique individuals. Some people may have more than one type of coverage and could be counted in multiple categories. Enrollment totals do not include uninsured residents; as of 2023, an estimated 5.5 percent of Oregonians were uninsured. The Medicare category includes both traditional Medicare and Medicare Advantage plans.

Figure 1: Oregon Health Insurance Enrollment by Market and Payer



11 Oregon State Legislature. Senate Bill 824 (2025). Available at: https://olis.oregonlegislature.gov/liz/2025R1/Measures/Overview/SB824

Findings – nonquantitative treatment limitations (NQTL)

As a result, this year's report focuses primarily on the application and analysis of NQTLs and quantitative data from MCAS. The findings are based on NQTL reports and supporting materials submitted to DCBS by insurers in March 2025, as well as annual MCAS data reported to NAIC. Although gaps in certain quantitative data limit trend analysis, DCBS remains committed to monitoring parity compliance through ongoing reviews of NQTL practices and regulatory oversight. This narrower scope is temporary; with the passage of Senate Bill 824 (2025), key quantitative reporting requirements will resume in 2026, restoring the department's ability to conduct more robust parity evaluations.

As explained above, the scope and methodology of the 2025 report were shaped by statutory changes. Certain quantitative data reporting requirements expired as scheduled on Jan. 1, 2025, under Oregon law, resulting in a greater emphasis on NQTL analysis and use of MCAS data for this year's assessment. This means insurers were not required to submit specific quantitative data on:

- The number and outcomes of denials and appeals for behavioral health and substance use disorder or medical/surgical benefits.
- The percentage of claims paid to in-network and out-of-network providers, including partial payments.
- Median maximum allowable reimbursement rates for provider contracted rates and incurred claim rates by visit billing code.
- Time-based office visit reimbursement rates, including breakdowns by geographic region or as a percentage of Medicare.
- Telehealth.

Methodology

To prepare for this report, DCBS provided insurers with standardized reporting forms for NQTL analysis.[12] Insurers were required to describe their policies and procedures for applying NQTLs to behavioral health/substance use disorder and medical/surgical benefits, and to identify the evidentiary standards and sources used in the development and implementation of these requirements. Insurers also submitted supporting materials and documentation as needed to clarify their NQTL practices.

Department staff reviewed the submitted NQTL reports and worked with each insurer individually to resolve inconsistencies, clarify information, and ensure completeness. This included follow-up

12 Reporting forms and other information can be found on DFR's website: https://dfr.oregon.gov/business/reg/health/pages/mental-health-parity.aspx.

communication when reported data appeared incomplete or unclear.

The findings in this report are based on the department's review and analysis of NQTL documentation submitted for the 2024 calendar year. DCBS will continue to adjust its methodology and monitoring practices as reporting requirements evolve, with the goal of supporting ongoing compliance with behavioral health parity laws.

Overview of NQTLs

A NQTL is any restriction on the availability, scope, or duration of behavioral health/substance use disorder benefits that is not expressed numerically. Federal and state parity laws, including MHPAEA and ORS 743A.168, require that NQTLs be applied comparably to behavioral health/substance use disorder and medical/surgical benefits within the same classification. Examples of NQTL's 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.

Each NQTL must be evaluated in two ways under parity law:

- "As written" refers to the insurer's documented policies, procedures, and standards, such as internal guidelines for prior authorization, provider credentialing, or step therapy requirements.
- "In operation" refers to how those policies are applied in practice, such as whether medical necessity reviews are enforced consistently and comparably across behavioral health/substance use disorder and medical/surgical services.

Evidentiary standards

Evidentiary standards refer to the criteria and procedures that insurers must follow to substantiate their policy decisions, such as benefit limitations or exclusions. These standards may rely on medical evidence, expert opinions, or other relevant information. Under ORS 743B.427, insurers are mandated to report the evidentiary standards used for the NQTL factors and all sources used in the design or application of NQTLs for both behavioral health/substance use disorder and medical/surgical benefits.

Key observations for 2025

In 2025, DCBS conducted a comprehensive review of insurer-submitted comparative analysis of NQTLs, as required by state and federal parity laws. This year's review considered both the content and sufficiency of insurers' written and operational responses, including supporting documentation related to how NQTLs are applied in practice.

General Observations

Most insurers submitted enough documentation to support "as written" compliance. However, most did not provide the level of detail or operational evidence needed to show parity "in operation."

Many failed to demonstrate that the processes and standards outlined in policy documents are actually applied comparably to both behavioral health/substance use disorder and medical/surgical benefits.

Insurers' approaches to documenting NQTLs varied widely, with some offering detailed explanations and others providing only brief or generic responses.

Disparities in Application

A key observation from this year's review is that differences remain in how NQTLs are applied to behavioral health/substance use disorder benefits compared to medical/surgical benefits. Analysis of in-operation data indicates that certain medical management techniques, such as prior authorization, concurrent review, and step therapy, may result in higher denial rates for behavioral health/substance use disorder services in some cases. While documentation quality varied, several insurers submitted operational data that showed measurable differences in how these NQTLs are applied across benefit types. These disparities suggest that, in practice, some NQTLs continue to pose access barriers for behavioral health/substance use disorder services that are not consistently mirrored in medical/surgical care.

Operational Evidence and Gaps

Many insurers continue to fall short in providing "in operation" analysis for important NQTLs, such as provider reimbursement rates, concurrent review, and provider network admission. In several instances, insurers were unable to demonstrate, with specific examples or evidence, that policies and procedures are applied comparably across benefit types. This ongoing lack of transparency and standardized reporting makes it difficult to evaluate and ensure parity in real-world application.

Figure 2: Summary of Common Gaps in NQTL Comparative Analyses – 2025 Review

NQTL category	Common issues observed	% of insurers with insufficient "in operation" documentation
Provider reimbursement rates	No evidence of comparable reimbursement practices for behavioral health/substance use disorder services versus medical/surgical services	75%
Concurrent review	Lacking demonstration of comparable application to behavioral health/substance use disorder services and medical/surgical services	75%
Provider network admission/ credentialing	Gaps in evidence for consistent network admission or credentialing standards	42%
Prior authorization	No clear comparison of prior authorization processes or outcomes	33%
Rx formulary design/step therapy	Stricter controls or insufficient comparison to medical/surgical services	33%

Application of NQTLs

The review identified recurring patterns suggesting behavioral health/substance use disorder services may be more frequently subject to restrictive management techniques. Several insurers submitted in-operation data indicating higher rates of prior authorization denials, more frequent utilization reviews, and more restrictive step therapy protocols compared to medical/surgical services. In addition, some filings described additional documentation requirements and limitations based on provider type, treatment setting, or admission standards that appeared more commonly in the application of behavioral health/substance use disorder benefits.

Methods and evidentiary standards

Most insurers reference nationally recognized guidelines, such as the American Society of Addiction Medicine Criteria, Milliman Care Guidelines, and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), along with internal claims data and plan documents to justify their NQTLs. While these references typically satisfy the "as written" requirement, insurers often provided insufficient detail on how these evidentiary standards are interpreted or operationalized in a comparable manner across behavioral health/substance use disorder and medical/surgical benefits. For example, insurers frequently cited company-developed algorithms or internal review committees without explaining how decisions are made or consistently applied in practice, limiting DCBS' ability to verify parity with "in-operation" medical management standards.

Prior authorization, concurrent review, and medical necessity determinations remain the most common NQTLs across both behavioral health/substance use disorder and medical/surgical services. While most insurers state they use similar criteria for both, operational evidence is often limited or missing. Reviews found that behavioral health/substance use disorder services are sometimes subject to more frequent or intensive management, such as lower thresholds for utilization review or stricter requirements for medical necessity, without clear parallels for medical/surgical services.

Provider network admission and access

Insurance companies generally report using the same credentialing standards for both behavioral health/substance use disorder and medical/surgical providers, but persistent gaps remain in behavioral health/substance use disorder network availability and provider reimbursement. The market continues to face challenges in ensuring adequate access to specialty behavioral health/substance use disorder providers, resulting in greater reliance on out-of-network care for these services. Administrative burdens and lower reimbursement rates for behavioral health/substance use disorder providers also remain common.

Coverage restrictions based on location, facility type, or provider specialty

Some insurers continue to apply additional restrictions to behavioral health/substance use disorder services based on the setting of care or the provider's licensure. For example, residential treatment or intensive outpatient programs for behavioral health/substance use disorder services may require extra documentation or prior authorization, while similar restrictions do not always apply to comparable medical/surgical care. Exclusions based on provider specialty also appear more frequently for behavioral health/substance use disorder services.

Transparency and reporting of NQTL application

Transparency remains inconsistent across the market. While some insurers provide detailed descriptions of NQTL policies and operational processes, others submit only general statements or minimal documentation. The lack of standardized, clear reporting makes it challenging to evaluate whether NQTLs are applied comparably to behavioral health/substance use disorder and medical/surgical services.

NQTL summary

The 2025 review highlights persistent challenges with parity compliance in Oregon's commercial insurance market. While most insurers provide sufficient documentation to support "as written" compliance, the majority still fall short on demonstrating parity "in operation." The most commonly missed areas are provider reimbursement rates, concurrent review, provider network admission, prior authorization, and formulary design or step therapy. In these categories, significant proportions of insurers lacked adequate evidence that behavioral health/substance use disorder restrictions are applied comparably to medical/surgical benefits.

Operationally, behavioral health/substance use disorder services appear to be subject to management techniques that could limit access more frequently and more stringently than medical/surgical services. Several insurers submitted operational data that indicated disparities, such as higher denial rates for certain prior authorization and utilization review processes, or additional documentation requirements for specific behavioral health/substance use disorder services. However, inconsistencies in reporting and variability in documentation quality across insurers make it difficult to definitively assess the extent of these operational disparities market-wide. Despite referencing national guidelines and internal standards, insurers often do not clearly demonstrate that these are applied equally across behavioral health/substance use disorder and medical/surgical services. The lack of standardized comparative analyses and supporting data remains a barrier to meaningful oversight and robust parity enforcement.

Overall, while some progress has been made in documenting NQTLs, substantial gaps in operational evidence and application remain. Addressing these market-wide challenges, particularly with clearer comparative analyses and more transparent operational reporting, will be essential to advancing parity and improving behavioral health access in Oregon.

Quantitative data

NAIC Market Conduct Annual Statement (MCAS)[13]

As stated previously, a sunset provision in House Bill 3046 (2021) resulted in previously required quantitative data regarding behavioral health/substance use disorder and medical/surgical services to no longer be required of insurers as of Jan. 1, 2025.

However, Oregon Senate Bill 824 (2025) was recently passed and restores quantitative data reporting requirements effective Jan. 1, 2026, for the purpose of DCBS' behavioral health parity analysis. The restoration of quantitative data reporting requirements for insurers will allow DCBS to resume a more comprehensive analysis of quantitative data metrics to ensure that insurers are complying with state and federal behavioral health parity regulations.

For this 2025 behavioral health parity report, DCBS is only able to conduct a narrow quantitative data parity analysis for the NQTL category, prior authorization. For this analysis, DCBS is utilizing prior authorization data that insurers reported to NAIC in May 2024, utilizing the "Health" MCAS data reporting template[14] (Appendix B). Due to NAIC's and DCBS' data validation timelines, the prior authorization data referenced in this report is from the 2023 NAIC MCAS.[15]

NAIC's MCAS prior authorization NQTL data source is the only quantitative data that DCBS has available in 2025 to make a quantitative data comparison between behavioral health/substance use disorder and medical/surgical services.

13 MCAS 2024 – Market Conduct Annual Statement, National Association of Insurance Commissioners. Available at: https://content.naic.org/mcas-2024.htm

14 MCAS Health Data Elements (2023), National Association of Insurance Commissioners. Available at: https://content.naic.org/sites/default/files/inline-files/Health%202023.0.1.pdf

15 MCAS 2023 – Market Conduct Annual Statement, National Association of Insurance Commissioners. Available at: https://content.naic.org/mcas-2023.htm

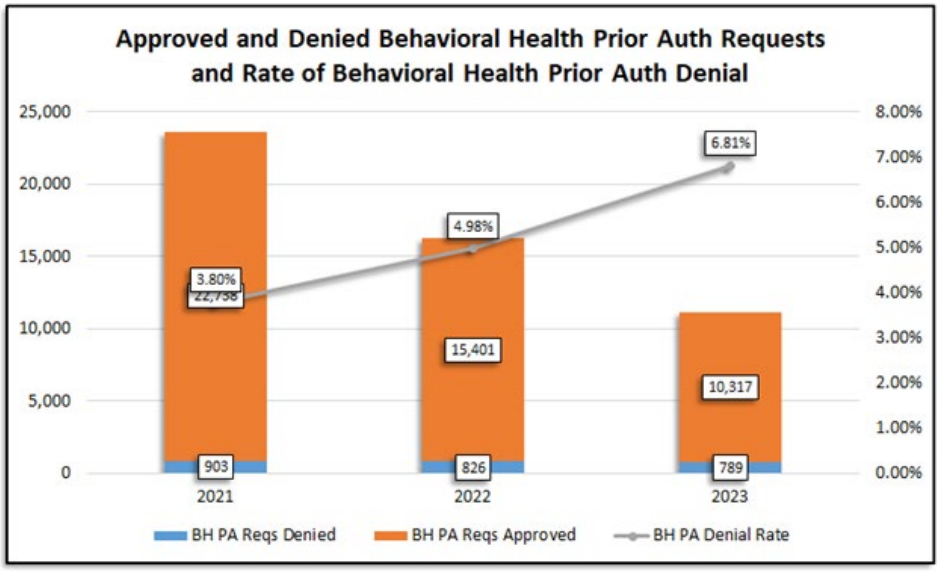


Figure 3. Approved and Denied Behavioral Health Prior Authorization Requests and the Rate of Behavioral Health Prior Authorization Denial

Source: 2023 NAIC MCAS report

Figure 3 shows that the total annual number of behavioral health/substance use disorder prior authorization requests decreased more than 50 percent from 2021 to 2023. It is possible that commercial insurers' COVID-19-related waivers and flexibilities for prior-authorization in effect during this time period was a factor. In addition, the frequency of telehealth behavioral health/substance use disorder-related provider visits may have been reduced during this time period. The behavioral health/substance use disorder prior authorization request denial rate increased by 3.01 percent from 2021 to 2023. DCBS is unable to conclusively explain the reason for these rate changes.

Figure 4 shows that the total annual number of medical/surgical prior authorization requests decreased slightly from 2021 to 2023. It is possible that commercial insurers' COVID-19-related waivers and flexibilities for prior-authorization in effect during this time period was a factor. DCBS is unable to conclusively explain the reason for the decrease. The medical/surgical prior authorization request denial rate increased by 0.46 percent from 2021 to 2023; and the number of prior authorization requests that were approved or denied remained relatively level from 2021 to 2023.

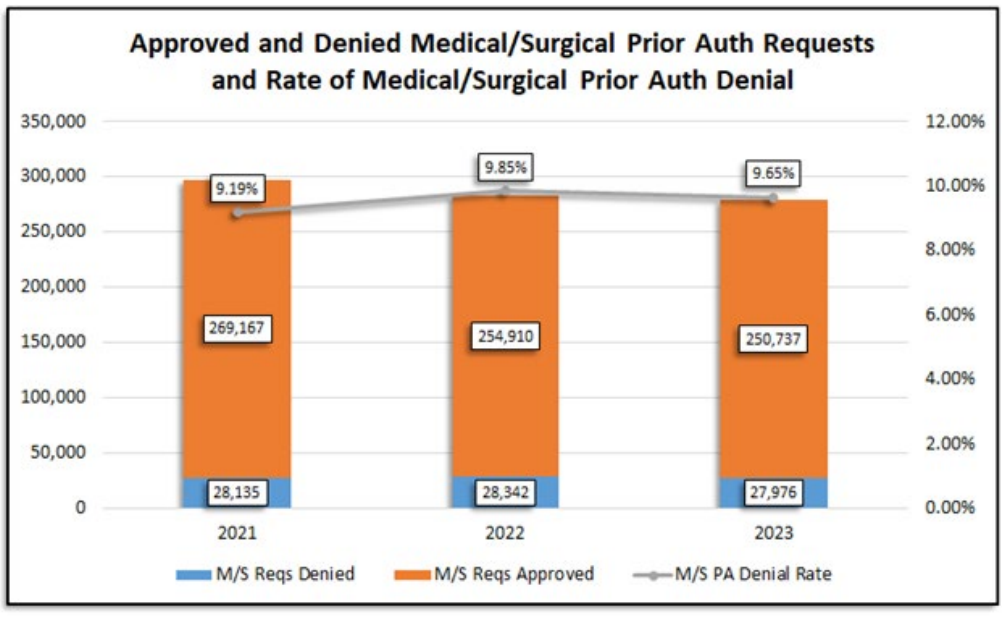


Figure 4. Approved and Denied Medical/Surgical Prior Authorization Requests and Rate of Medical Surgical Prior Authorization Denial

Source: 2023 NAIC MCAS report

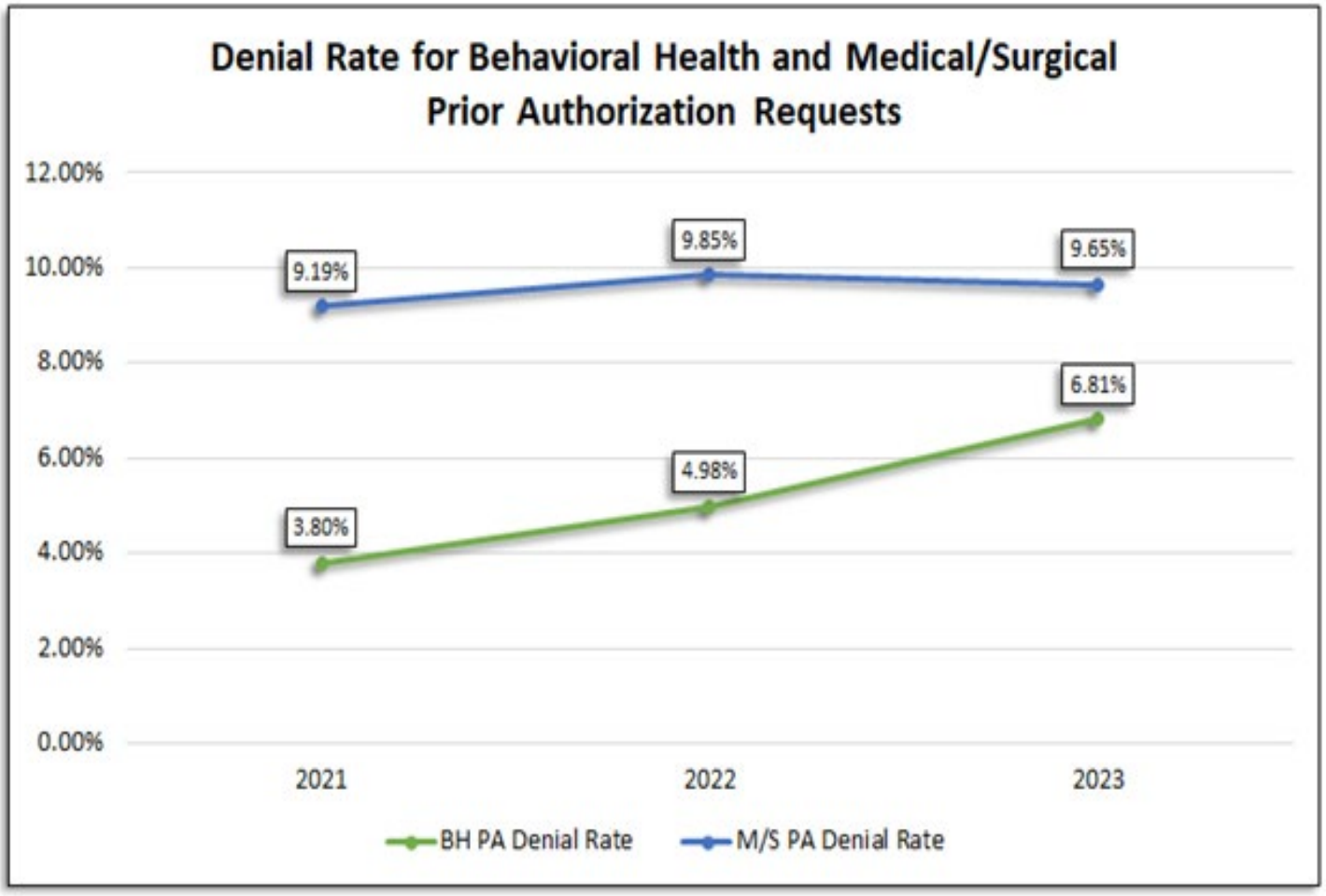
Figure 5 shows that the rate of prior authorization request denials for behavioral health/substance use disorder compared to medical/surgical for years 2021 through 2023 was at a higher rate relative to the total number of requests for behavioral health/substance use disorder versus medical/surgical services. This could be an indicator of insurers not applying the NQTL of prior authorization in full parity. Additionally, the number of prior authorization requests are larger for medical/surgical than behavioral health, which could explain why the percentage is larger. Detailed "in-operation" NQTL comparative analyses are needed for DCBS to make any concrete findings.

Figure 5. Denial Rate for Behavioral Health and Medical/Surgical Prior Authorization Requests

Background on DCBS prior authorization insurer data reporting requirements

ORS 743B.250, requires all insurers offering a health benefit plan in Oregon to provide to the department, in the format prescribed by the department, an annual summary of the insurer's aggregate data regarding: grievances; internal appeals; requests for external review; and requests for prior authorization received by the insurer.

OAR 836-053-1070, Format and Contents; describes the form and manner prescribed by the department for the annual summary of the insurers' aggregate data that is to be reported. This data is due to DCBS' Division of Financial Regulation by June 30 annually. Historically, the prior authorization data that is reported has not separated behavioral health/substance



use disorder data from medical/surgical for the following:

- The number of requests received.
- The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer.
- The number of requests that were initially approved.
- The number of denials that were reversed by internal appeals or external reviews.

In early 2025, DCBS revised the reporting template to have insurers separate prior authorization data for behavioral health/substance use disorder and medical/surgical. The data reported is being validated and is not available to use for this year's behavioral health parity report due to publishing deadlines.

However, House Bill 3134 (2025) was recently passed and will require DCBS to publish insurers' prior authorization data reports, not identifying individual insurers, by March 1 of each year.

In addition, House Bill 3134 amended the prior authorization data metrics that insurers are required to annually report in 2026 to:

- The percentage and number of standard prior authorization requests that were approved.
- The percentage and number of standard prior authorization requests that were denied.
- The percentage and number of standard prior authorization requests that were approved after appeal.
- The percentage and number of all prior authorization requests for which the time frame for review was extended and the request was approved.
- The percentage and number of expedited prior authorization requests that were approved.
- The percentage and number of expedited prior authorization requests that were denied.
- The average and median times that elapsed between the submission of a request and a determination by the insurer for standard prior authorization.
- The average and median times that elapsed between the submission of a request and a decision by the insurer for expedited prior authorization.

Conclusion

The 2025 Behavioral Health Parity Report highlights ongoing challenges and areas for improvement in Oregon's commercial insurance market. While insurers generally meet requirements "as written," significant gaps remain in demonstrating parity "in operation," especially in prior authorization, provider reimbursement, concurrent reviews, provider credentialing, and formulary management. Persistent disparities and higher denial rates for some behavioral health services underscore the need for increased transparency and clearer comparative analyses.

Recent legislative efforts –including Senate Bill 824 (2025), which reinstates quantitative reporting requirements – aim to improve oversight and enforcement.[16] Effective parity implementation will require continued compliance monitoring, as well as broader system-level reforms to address workforce shortages, treatment capacity, and access barriers across both behavioral and physical health systems.

DCBS will continue collaborating with insurers to strengthen operational parity practices, refine reporting standards, and promote equitable access to behavioral health and substance use disorder services for all Oregonians.

16 See also Senate Bill 822 (2025), which expands network adequacy standards to large group plans and introduces additional requirements related to provider access and geographic coverage.

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/NQTL-Reporting-Form.docx

Appendix B: Market Conduct Annual Statement template

The MCAS template provides the structured format and data elements insurers must submit annually to the NAIC. Key components include:

- Profiles of health plan categories (e.g., in-exchange individual, large group, small group).
- Volume and outcomes of prior authorization requests, broken down by behavioral health/substance use disorder and medical/surgical benefit categories.
- Claims processing timelines, denials, approvals, and appeals information.
- Grievance and review activity, including internal and external appeal metrics.
- Financial and administrative data such as premiums, member months, and cost-sharing responsibilities.
- https://content.naic.org/sites/default/files/inline-files/Health%202023.0.1.pdf