836-053-1430
Form and manner for behavioral health benefits reporting

(1) An insurer offering individual or group health benefit plans must submit its annual report for behavioral health benefits no later than March 1 of each year.

(2) General requirements for reporting and submitting information on behavioral health benefits include, submitting information from the previous calendar year in an electronic format specified by the department that adheres to standards set forth on the department's website.

(3) Beginning March 1, ~~2022~~2026, annual reporting on behavioral health benefits shall include:

(a) The following information submitted in accordance with standards posted on the department's website and in compliance with federal reporting requirements specified in 42 U.S.C. 300gg-26(a)(8)(A), 29 U.S.C. 1185a(a)(8)(A), and 26 U.S.C. 9812(a)(8)(A):

(A) Plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a clear description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(B) Factors used to determine if nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(C) Evidentiary standards used for the factors identified in paragraph B of this subsection, when applicable, provided that every factor is defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.

(D) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.

(E) The specific findings and conclusions reached by the insurer with respect to the health insurance coverage, including any results of the analyses described in paragraphs A to D of this subsection that indicate that the plan or coverage is or is not in compliance with ~~Oregon Laws 2021, chapter 629, section 2.~~ORS 743B.427.

~~(b) Additional information in the annual behavioral health benefits report until January 1, 2025 includes:~~

(~~A~~F) Denial information for all denials (including full or partial denials) on the:

(i) Number of denials of behavioral health benefits and medical and surgical benefits,

(ii) Number and P~~p~~ercentage of denials that were appealed,

(iii) Percentage of appeals where an initial decision has not been made,

(~~iii~~iv) Percentage of appeals that upheld the denial, and

(~~i~~v) Percentage of appeals that overturned the denial.

(~~B~~G) Percentage and total count of claims paid to in-network providers and out-of-network providers for behavioral health benefits and medical and surgical benefits. This includes any partial claims paid to providers for behavioral health benefits and medical and surgical benefits.

(~~C~~H) The median maximum allowable reimbursement rate for both provider contracted rates and incurred claim rates for each time-based office visit CPT billing code as specified on the department's website.

(i) Median maximum allowable reimbursement rates will include the range and median absolute deviation for both provider contracted rates and incurred claim rates for in-network and out-of-network providers by each time-based office visit billing code. This should include a description as to whether these rates follow a normal distribution or if there are any notable differences in distribution.

(ii) Provider types for behavioral health and medical and surgical will be reported according to the groupings identified on the department's website.

(iii) A description of how incentive payments were factored into the calculation of the median maximum allowable reimbursement rate.

(~~D~~I) Time-based office visit reimbursement rates must be reported as the median rate by each geographic region in the state for the health care providers specified in Oregon Laws ~~2021~~2025, chapter ~~629~~X, section ~~21~~.

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(i) Time-based reimbursement rate information will be grouped by CPT billing code specifying the amount of time (i.e., 30, 45, or 60 minutes). CPT billing codes will be identified on the department's website.

(ii) Calculation of the percentage of the Medicare rate of reimbursement should compare the Medicare rate to the median maximum allowable reimbursement rate for the CPT billing code by provider type.

(EJ) Descriptions and documentation on the policies, procedures, and other efforts to maintain compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110343) and ORS 743A.168, and rules adopted thereunder.

(KF) Other data and information to demonstrate compliance with state and federal mental health parity requirements will include reporting on:

(i) Telehealth claims including:

(I) Number of telehealth claims for behavioral health and medical and surgical.

(II) Any differences in the median maximum allowable reimbursement rate for telehealth claim related to care provided by a behavioral health provider or a medical or surgical provider.

(III) Other relevant information or differences in telehealth policies and procedures between behavioral health and medical and surgical benefits.

(ii) Compliance with ORS 743A.168 including:

(I) Update all behavioral health plan coverage documents and policies to reflect coverage requirements specified in ORS 743A.168(2)(c).

(II) Summary of how the insurer's network of behavioral health providers meets the standards in ORS 743B.505 including:

(a) Whether providers with no claims experience are included in the analysis of the insurer's network and the ratio of these providers to providers with claims experience.

(b) Steps taken by the insurer to provide a diverse network of providers to their enrollees evaluated by components such as geographic area, spoken language, and cultural competency.

(III) Criteria, frequency, and the methodology used to set reimbursement rates for behavioral health providers and medical and surgical providers. Any notable differences in methodology should be reported.

(IV) Summary of the clinical and evidence-based sources used to determine "generally accepted standards of care" as defined in ORS 743A.168.

(V) Summary of the criteria and guidelines used to make level of care placement decisions and process for updating the criteria and guidelines.

(4) All information submitted to the department under this rule is confidential and not subject to public disclosure, as provided in ORS 705.137.

Statutory/Other Authority: ~~Or Laws 2021, ch 629~~;ORS 743B.427; SB 824 (2025); ORS 731.244

Statutes/Other Implemented: ~~Or Laws 2021, ch 629~~ORS 743B.427; SB 824 (2025)

History:

ID 1-2022, adopt filed 02/11/2022, effective 02/15/2022

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Summary Table of Amendments

Item	Rule Location	Change Needed?	Example Edit
Denials/Appeals	(F)	Clarify for total, appealed, pending	See above
Paid Claims	(G)	Add “total count” if desired	See above
Contracted Rates	(H)	Already covered; clarify if needed	
Telehealth Claims	(K)(i)	Already in rule	No change
Confidentiality	(4)	Already in rule	No change