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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
11/23/2021 4:56 PM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: Behavioral health benefit reporting requirements, Or Laws 2021, ch 629

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 12/31/2021 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Salem,OR 97301

Filed By:
Karen Winkel
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 12/17/2021
TIME: 11:00 AM
OFFICER: Cassie Soucy
ADDRESS: Labor & Industries Building
350 Winter St NE
Salem, OR 97301
SPECIAL INSTRUCTIONS:
Virtual due to COVID-19
Microsoft Teams Meeting:
Call in (audio only)
+1 503-446-4951,,976773347# United States, Portland
Phone Conference ID: 976 773 347#

NEED FOR THE RULE(S)

2021 House Bill 3046 (the law), enrolled at Oregon Laws 2021, chapter 629, establishes new requirements for individual and small group health benefit plans providing behavioral health benefits to report to the Department of Consumer and Business Services (the department) annually on or before March 1 to the division.

The reporting requirements specify that the health benefit plans report on nonquantitative treatment limits including a comparative analysis to medical and surgical benefits. Nonquantitative treatment limits (NQTLs) are defined in law as a limitation that is not expressed numerically but otherwise limits the scope or duration of behavioral health benefits. NQTLs may include but are not limited to prior authorization, fail-first protocols, probability of improvement, and others. Documentation and reporting NQTLs and the comparative analysis to medical and surgical benefits is required by the Consolidated Appropriations Act, 2021 which amended the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

The law includes additional reporting requirements denials, claims, and the median maximum allowable reimbursement rate for behavioral health benefits and medical and surgical benefits. Finally insurers are required to report on findings or conclusions demonstrating compliance with the MHPAEA and ORS 743A.168 as well as any other data or information the department deems necessary.

The department is required to report to the interim committees of the Oregon Legislature no later than September 15 of each year on the comparison of carrier coverage of mental health treatment and services to coverage of medical and surgical treatment and services.

Oregon Laws 2021, chapter 629 includes several other provisions related to requirements for behavioral health benefits and treatment which require rulemaking. The department will be pursuing these rules at a future date.

The proposed rules provide clarity to the form and manner for carriers offering individual and group health benefit plans to report on behavioral health benefits. Specifically, the rules clarify certain definitions and expectations for the reporting to be submitted to the department. Data elements are further expanded upon when additional clarity was determined to be necessary and helpful for vague terminology or information required by Oregon Laws 2021, chapter 629.

Based on financial filings made to DFR, no health insurers meet the definition of a small business under ORS 183.310, because no health insurer is independently owned and operated.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Draft rules are available from Karen Winkel, Rules Coordinator, Division of Financial Regulation located at 350 Winter St. NE, Salem, OR 97301 and are available on the division's website:
https://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx.

Oregon Laws 2021, chapter 629 (Enrolled House Bill 3046) may be found on the Oregon Legislative Assembly website:
https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB3046.

ORS 743A.168 may be found on the Oregon Legislative Assembly website:
https://www.oregonlegislature.gov/bills_laws/ors/ors743a.html.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as applied to the individual and group market are promulgated at 42 U.S.C. 300gg-26 which may be found on the Federal Government Publishing Office website: https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap6A-subchapXXV-partA-subpart2-sec300gg-26.

FISCAL AND ECONOMIC IMPACT:

Oregon Laws 2021, chapter 629 and the proposed rules will have a direct economic impact on health insurers required to report on behavioral health benefits. Based on the information available to DCBS, none of the impacted health insurers are small businesses.

Based on the information available to DCBS, the proposed rules would not have any additional fiscal or economic impact on state agencies, local governments, the public, nor small businesses beyond the underlying statutory requirements.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Based on information currently available to DCBS, the proposed rule would not have a fiscal or economic impact on state agencies, local government units, nor the public.

The underlying statutory provisions have an impact on DCBS through administrative and data analysis work for DCBS staff to report back to the Legislative Assembly on the behavioral health data submitted by insurers. However, the proposed rule will not have these impacts. The proposed rules provide finer details regarding the implementation of the law's requirements and are expected to have a negligible impact on costs to the department.

The proposed rules do not add any new requirements on public entities, but instead clarify DCBS's supervisory expectations with regard to health insurers' reporting behavioral health data. Some state agencies are impacted by the underlying statutory provisions. However, these agencies as well as other state agencies and local governments are not expected to incur any fiscal impact from the proposed rules.

Based on the information currently available to DCBS, the proposed rule does not have an economic impact on the general public beyond the underlying statutory requirements.

(2)(a) The proposed rules clarify the reporting requirements for health insurers to submit behavioral health data. Compliance with these requirements may require significant costs for insurers. DCBS does not have data on the specific number of employees employed by insurers authorized to transact insurance in Oregon, but it is unlikely that any of the health insurers to which this rule applies are small businesses.

DCBS convened a rulemaking advisory committee, which included representatives of behavioral health care providers, insurers, and consumer and patient advocates.

(2)(b) The proposed rules provide clarity to the behavioral health benefit reporting and require additional compliance reporting for health insurers. The underlying statute provides authority for the department to require any other information to assess compliance. The proposed rules require additional information health insurers to report information about compliance with ORS 743A.168. The clarifications and additional information on behavioral health benefit may impose reporting and administrative costs on health insurers to comply with the requirements.

Based on financial filings made to DFR, no health insurers meet the definition of a small business under ORS 183.310, because no health insurer is independently owned and operated.

(2)(c) The proposed rules provide clarity to the behavioral health benefit reporting and require additional compliance reporting for health insurers. The underlying statute provides authority for the department to require any other information to assess compliance. The proposed rules require additional information health insurers to report information about compliance with ORS 743A.168. The clarifications and additional information on behavioral health benefit may impose labor and administration costs on health insurers to comply with the requirements.

Based on financial filings made to DFR, no health insurers meet the definition of a small business under ORS 183.310, because no health insurer is independently owned and operated.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

DCBS convened a rulemaking advisory committee, which included representatives of behavioral health care providers, insurers, and consumer and patient advocates. Some behavioral health care providers are small businesses. The rulemaking advisory committee met on August 26, Sept. 8, Sept. 23, and Sept. 30, 2021.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:

836-053-1420, 836-053-1425, 836-053-1430

ADOPT: 836-053-1420

RULE SUMMARY: Adopt to establish reporting of behavior health benefits.

CHANGES TO RULE:

836-053-1420
Purpose and statutory authority
The purpose of OAR 836-053-1420 to 836-053-1430 is to establish the form and manner for carriers offering individual and group health benefit plans to report on behavior health benefits.
Statutory/Other Authority: Or Laws 2021, ch 629
Statutes/Other Implemented: Or Laws 2021, ch 629

ADOPT: 836-053-1425

RULE SUMMARY: Adopt definitions for behavioral health benefit reporting.

CHANGES TO RULE:

836-053-1425
Definitions for behavioral health benefit reporting
As used in these rules:¶
(1) "Behavioral health benefits" means insurance coverage of mental health treatment and services and substance use disorder treatment and services.¶
(2) "Geographic region" means the regions identified as the specific geographic divisions for Oregon's individual and small group market as required by OAR 836-053-0465.¶
(3) "Incentive payment" means any compensation arrangement, including but not limited to coordination fees, withholds, bonuses, capitation, or any other compensation, to pay a provider or provider group directly or indirectly.¶
(4) "Median maximum allowable reimbursement rate" means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.¶
(5) "Partial denial" means the denial and non-reimbursement of portions of a medical claim submitted for services or supplies provided to a covered enrollee as specified in the plan documents.¶
(6) "Time-based office visit" means an in-person office or telehealth visit between a health care provider and a patient in specific increments as determined by the relevant CPT billing code.
Statutory/Other Authority: Or Laws 2021, ch 629
Statutes/Other Implemented: Or Laws 2021, ch 629

ADOPT: 836-053-1430

RULE SUMMARY: Adopt the form and manner for behavioral health benefit reporting.

CHANGES TO RULE:

836-053-1430
Form and manner for behavioral health benefit 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, 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.¶
(b) Additional information in the annual behavioral health benefits report until January 1, 2025 includes:¶
(A) 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) Percentage of denials that were appealed,¶
(iii) Percentage of appeals that upheld the denial and¶
(iv) Percentage of appeals that overturned the denial.¶
(B) Percentage 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) 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) 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, chapter 629, section 2.¶
(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.¶
(E) 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.¶
(F) 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:¶
(1) 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.¶
(2) 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.
Statutory/Other Authority: Or Laws 2021, ch 629
Statutes/Other Implemented: Or Laws 2021, ch 629