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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

FILED
09/26/2025 9:55 AM
ARCHIVES DIVISION
SECRETARY OF STATE

CHAPTER 836
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE REGULATION

FILING CAPTION: 2025 Behavioral Health Parity Rule

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/29/2025 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.

CONTACT: Karen Winkel
503-947-7694
dfr.rules@dcbs.oregon.gov

Labor and Industries Building
350 Winter St. NE
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: 10/22/2025
TIME: 2:30 PM
OFFICER: Brooke Hall

IN-PERSON HEARING DETAILS
ADDRESS: Labor and Industries Building, 350 Winter St. NE, Basement, Conf Rm E, Salem, OR 97301

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 503-446-4951
CONFERENCE ID: 678901164
SPECIAL INSTRUCTIONS:
This is a hybrid meeting conducted in-person and virtually via Microsoft Teams:
Meeting ID: 264 998 925 736 7
Passcode: wH3Tz9KJ
NOTE: PUBLIC COMMENTS ARE PUBLIC RECORDS AND WILL BE POSTED ON THE DFR RULEMAKING WEBPAGE.

NEED FOR THE RULE(S)

Rulemaking is necessary to implement Senate Bill 824 (2025), which restores and makes permanent quantitative data reporting requirements for behavioral health parity under ORS 743B.427 and establishes new confidentiality protections for carrier-submitted data. SB 824 directs the Department of Consumer and Business Services (DCBS) to update its rules to reflect these statutory changes and to ensure ongoing compliance with both state and federal behavioral health parity laws.

The proposed rule removes the previous sunset language that would have ended quantitative reporting in 2025 and

adds language ensuring all data reported by carriers to DCBS is confidential and not subject to public disclosure. It also updates statutory citations and clarifies data submission requirements in line with the statute.

To inform the rulemaking process, DCBS convened a Rulemaking Advisory Committee (RAC) that included representatives from health insurers, health care providers, consumer and patient advocates, and state agency staff. Small business interests were represented by independent provider groups and advocacy organizations that serve or include small businesses. The RAC provided feedback on draft rule language, data collection practices, and potential impacts on equity and administrative burden, helping to ensure that the final rule is both practical and responsive to stakeholder needs.

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.

STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The proposed rules implement the provisions of SB 824 without having a significant substantive effect beyond the underlying statutory provisions. Passage of SB 824 is expected to advance health equity in Oregon by improving oversight and enforcement of behavioral health parity requirements. By enacting the provisions of the new law, the rule strengthens quantitative data reporting, which helps to ensure that all individuals, regardless of their insurance plan, geography, or demographic background, have equitable access to behavioral health services on par with medical and surgical benefits.

These changes will directly impact health insurers and indirectly affect health care providers and consumers who use behavioral health benefits. Improved data collection will help identify disparities in access or treatment outcomes among different populations, including historically underserved groups such as communities of color, rural residents, and low-income individuals.

The rulemaking process involved a diverse Rulemaking Advisory Committee, including representatives from small businesses, independent providers, and consumer advocacy groups, to help ensure the final rule addresses a broad range of community needs and perspectives.

FISCAL AND ECONOMIC IMPACT:

Based on information available to DCBS, adoption of these rules is not expected to create significant new costs of compliance for most businesses, as the rule primarily maintains existing reporting requirements with only minor technical updates to align with SB 824. Most insurers are already collecting and submitting the required data as part of their current operations.

There may be minimal administrative costs for health insurers associated with updating internal processes or reporting templates to reflect the revised rule language. However, these costs are required by the underlying statutory amendments, not the proposed rules, can expected to be minor, and should not require significant new investments in technology or staffing.

For small businesses, including independent provider groups, the rule does not impose direct compliance costs, as reporting requirements apply to insurers and not to individual providers. No other material compliance costs for small businesses have been identified.

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

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 (or does not have) a fiscal or economic impact on state agencies, local government units, nor the public.

(2)(a) The only businesses subject to the rule are health insurance carriers. Based on financial filings made to DFR, no insurers meet the definition of a small business under ORS 183.310, because no insurer is independently owned and operated.

(2)(b) As noted above, the underlying statutory requirements may impose modest administrative costs on health insurance carriers, but the proposed rules are not expected to impose additional costs beyond the statute. The rule is not expected to have any impact on small businesses, as it maintains reporting requirements that insurers were already required to meet under previous rules and federal regulations. No new compliance or administrative burdens are created for small businesses.

(2)(c) As noted above, although there may be some modest costs imposed on health insurance carriers by the underlying statute, the proposed rules are not expected to impose additional costs beyond the statute. There are no significant new costs for professional services, equipment, supplies, labor, or administration expected as a result of this rule. The requirements maintain Oregon's existing insurer reporting obligations, so insurers should already have the systems and staff in place. As a result, no material increase in expenses is anticipated.

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

Behavioral health professionals served on the RAC who represented small businesses.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

AMEND: 836-053-1430

RULE SUMMARY: This rule governs annual data reporting requirements for health insurers related to behavioral health parity in Oregon. It implements changes required by SB 824 (2025), including:

- Restoring and making permanent the quantitative data reporting requirements for behavioral health parity.
- Adding confidentiality protections for carrier-submitted data.
- Updating statutory citations.

CHANGES TO RULE:

836-053-1430
Form and ~~m~~Manner for ~~b~~Behavioral ~~h~~Health ~~b~~Benefits ~~r~~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~~6~~, annual reporting on behavioral health benefits shall include:~~¶~~
~~(a) T~~ 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~~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~~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~~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~~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~~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 O~~regon Laws 2021, chapter 629, section 2.¶~~
~~(b) Additional information in the annual behavioral health benefits report until January 1, 2025 includes:¶~~
~~(A~~RS 743B.427.¶
(f) Denial information for all denials (including full or partial denials) on the:¶
(~~i~~A) Number of denials of behavioral health benefits and medical and surgical benefits~~;~~;¶
(~~ii~~B) Percentage of denials that were appealed~~;~~;¶
(~~iii~~C) Percentage of appeals that upheld the denial; and¶
(~~iv~~D) Percentage of appeals that overturned the denial.¶
(~~B~~g) 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~~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 and in accordance with Oregon Laws 2025, chapter 599, section 1.¶
(~~i~~A) 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~~B) Provider types for behavioral health and medical and surgical will be reported according to the groupings identified on the department's website.¶
(~~iii~~C) 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 202~~1~~5, chapter ~~62~~599, section ~~2~~1(3)(i and j).¶
(~~i~~A) 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~~B) 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~~j) 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~~k) Other data and information to demonstrate compliance with state and federal mental health parity requirements will include reporting on:¶
(~~i~~A) Telehealth claims including:¶
(~~I~~i) Number of telehealth claims for behavioral health and medical and surgical.¶
(~~II~~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~~iii) Other relevant information or differences in telehealth policies and procedures between behavioral health

and medical and surgical benefits.¶
(~~ii~~B) Compliance with ORS 743A.168 including:¶
(~~I~~i) Update all behavioral health plan coverage documents and policies to reflect coverage requirements specified in ORS 743A.168(2)(c).¶
(~~II~~ii) Summary of how the insurer's network of behavioral health providers meets the standards in ORS 743B.505 including:¶
(~~a~~I) 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~~II) 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~~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~~iv) Summary of the clinical and evidence-based sources used to determine "generally accepted standards of care" as defined in ORS 743A.168.¶
(~~V~~v) Summary of the criteria and guidelines used to make level of care placement decisions and process for updating the criteria and guidelines.¶
(C) Any additional data or information the department reasonably determines is necessary to assess compliance with state and federal behavioral health parity requirements, consistent with the authority granted under Oregon Laws 2025, chapter 599, section 1(3)(L).¶
(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: ORS 731.244, ORS 743B.427, Or Laws 202~~1~~5, ch ~~62~~599
Statutes/Other Implemented: ORS 743B.427, Or Laws 202~~1~~5, ch ~~62~~599