

836-053-14XX

Purpose and statutory authority

The purpose of OAR 836-053-14XX through XX 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: 2021 Or Laws ch 629
Statutes/Other Implemented: 2021 Or Laws ch 629

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Definitions for behavioral health benefit reporting

(1) As used in these rules:

- a. “Geographic region” means the regions identified as the specific geographic divisions for Oregon’s individual and small group market as required by federal rule (45 CFR Part 147).
- b. “Partial denial” means denial and non-reimbursement of certain conditions or parts of the claim submitted for services provided to a covered enrollee as specified in the plan documents.
- c. “Time-based office visit” means an office or telehealth visit where there is face-to-face time from a health care provider to a patient in specific increments as determined by the relevant CPT billing code.

Statutory/Other Authority: 2021 Or Laws ch 629
Statutes/Other Implemented: 2021 Or Laws ch 629

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Form and manner for behavioral health benefit reporting

- (1) An insurer offering individual or group health benefit plan 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 submit information that is for the previous calendar year, in an electronic format specified by the department, and 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 to standards posted on the department’s website that are in compliance with federal reporting

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requirements specified by 42 U.S.C. 300gg-26(a)(8)(A); 29 U.S.C. 1185a(a)(8)(A); 26 U.S.C. 9812(a)(8)(A):

- i. 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.
 - ii. Factors used to determine that the nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.
 - iii. 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.
 - iv. 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.
 - v. 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 this section.
- b. Additional information in the annual behavioral health benefit report until January 1, 2025 includes:
- i. Denial information which is specified for both full or partial denials on the:
 1. Number of denials of behavioral health benefits and medical and surgical benefits,
 2. Percentage of denials that were appealed,
 3. Percentage of appeals that upheld the denial and
 4. Percentage of appeals that overturned the denial.

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- ii. Percentage of claims paid to in-network providers and out-of-network providers for behavioral health benefits and medical and surgical benefits. This includes the percentage of partial claims paid to providers for behavioral health benefits and medical and surgical benefits.
- iii. The median maximum allowable reimbursement rate for billing codes for time-based office visit as specified on the department's website.
 - 1. Median maximum allowable reimbursement rates should include the range and median absolute deviation for each time-based office visit billing code. This should include a description of the distribution as to whether these rates follow a normal distribution or if there are any notable differences in distribution (i.e. outliers).
 - 2. Providers for behavioral health and medical and surgical will be reported according to the groupings identified on the department's website.
- iv. Time-based office visit reimbursement rates should be reported as the median rate by each geographic region in the state for all health care providers specified in law.
 - 1. Time-based reimbursement rate information will be grouped by the CPT billing code specifying the amount of time (i.e. 30, 45, or 60 minutes).
 - 2. Calculation of the percentage of the Medicare rate the reimbursement should compare the median Medicare rate to the median maximum allowable reimbursement rate for the CPT billing code by provider type.
- v. Compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) shall be determined by providing descriptions and documentation on the policies, procedures, and other efforts to maintain compliance.
- vi. Other data and information necessary to assess compliance with state and federal mental health parity requirements include reporting on:

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