HB 3046 – Mental health parity
Reporting requirements – discussion draft

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

836-053-14XX
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).

~~a.~~b. "Incentive payment" means any compensation arrangement, including but not limited to such as coordination fees, withholds, bonuses, capitation, or any other compensation, to pay a ~~physician~~provider or ~~physician~~provider group directly or indirectly.

~~b.~~c. "Partial denial" means the denial and non-reimbursement of portions of a medical claim submitted for services or supplies ~~certain conditions or parts of the claim submitted for services~~ provided to a covered enrollee as specified in the plan documents.

~~c.~~d. "Time-based office visit" means an in-person office or telehealth visit between ~~where there is face-to-face time from~~ a health care provider ~~to~~ and 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

836-053-14XX
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 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~~ all denials (including 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.

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 any ~~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 both provider contracted and incurred claim rates ~~billing codes~~ for time-based office visit billing codes as specified on the department's website.

   1. Median maximum allowable reimbursement rates ~~should~~ will include the range and median absolute deviation for both provider contracted rates and incurred claims for in-network and out-of-network providers by 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.

   ~~2.~~3. A description of how incentive payments were factored into the calculation of the median maximum allowable reimbursement rate.

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). CPT billing codes will be identified on the department's website.

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

v. Providing descriptions and documentation on the policies, procedures, and other efforts to maintain compliance with NQTLs applicable under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110 343) and ~~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~~with ORS 743A.168.~~.~~

~~v.~~1. ~~is~~

vi. Other data and information necessary to assess compliance with state and federal mental health parity requirements include reporting on:

1. Telehealth claims including:
   a. Number of telehealth claims for behavioral health and medical and surgical.
   b. 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.
   c. Other relevant information or differences in telehealth policies and procedures between behavioral health and medical and surgical benefits.

2. Compliance with ORS 743A.168 including:
   a. Updates to behavioral health coverage documents and policies to reflect coverage requirements specified in ORS 743A.168(2)(c).
   b. Summary of how the insurer's network of behavioral health providers meets the standards in ORS 743B.505 including:
      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.
      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.

c. Evaluation of the criteria and frequency the methodology is used to set reimbursement rates for behavioral health providers and medical and surgical providers is reviewed. Any notable differences in methodology should be reported.

d. Summary of the clinical and evidence-based sources used to determine “generally accepted standards of care”.

e. Identification of the tools used to determine the level of care placement decisions and process for updating tools.

~~vi.~~3.

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