Mental Health Insurance Coverage:
A Guide to State Parity Law

Insurance Parity for Mental Illness

Growing public awareness of the prevalence of mental illness and the cost-effectiveness of treatment has resulted in unprecedented support for parity—fair and equivalent insurance coverage of mental health disorders. Without parity, millions of Americans who have a mental illness encounter different financial limits and cost-sharing requirements, limited coverage and access to providers, exclusions of conditions, limits on types and duration of treatment, and other provisions that result in inadequate care and poor health outcomes.

State Parity Law

The majority of states now have some form of "parity" law, though these laws vary considerably in their provisions. Parity laws that include virtually all mental health and substance abuse disorders, ensure equal financial and durational treatment limits, and do not include cost caps or exclude small groups are often described as "comprehensive." Most state laws, in contrast, are limited in the extent to which they offer equivalent coverage.

This guide and accompanying chart of state mental health parity laws are designed to assist those who are seeking to understand, enact or strengthen state parity laws by providing information on key components of comprehensive parity laws, sample statutory language, and descriptions and links to current state laws.

Federal Parity Law

An estimated 82 million Americans are covered by plans that are subject to federal law and do not benefit from state mental health parity laws. As of spring 2007, federal parity legislation is under consideration in Congress that, if enacted, will play a critical role in mental health coverage. For more information on this legislation, please visit NAMI's website. To read NAMI's testimony in favor of insurance parity before the US House, click here.

Components of Parity Laws

Parity laws include multiple components, each of which can significantly affect access to and coverage of care for people with mental illness. In this section, major aspects of parity law are described and, in many cases, key considerations are outlined. Existing language from statute or legislation, where included, are intended as examples and do not necessarily represent "model law" language.

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I. Mandated Benefit (Coverage)

A mandate to provide mental health and substance abuse coverage is necessary to ensure that plans cannot opt out of covering mental health and substance abuse diagnosis and treatment. In many states, and in the proposed federal Senate bill, plans are only subject to parity requirements *if* they decide to offer mental health and substance abuse coverage.

Description

- Does mandate refer to policies *delivered, issued for delivery, renewed, amended, or continued* in the state? Be careful of language that allows loopholes for plans, particularly out-of-state, to avoid a mandate.
- Does mandate include both individual and small group policies?
- Does mandate apply to any health plan administered or offered by the state, or by any subdivision or instrumentality of the state (for example, the state's Medicaid plan, plans to cover the uninsured, S-CHIP programs, etc.)

Example of Language from Existing Statute or Legislation

From Connecticut Public Act No. 99-284, Sec. 27.

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery renewed, amended or continued in this state on or after January 1, 2000, shall provide benefits for the diagnosis and treatment of mental or nervous conditions.

From Annotated Code of Maryland, Insurance, Title 15. Health Insurance. Subtitle 8. Required Health Insurance Benefits.
§ 15-802. Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse

(b) Scope of section. -- This section applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis and that provides coverage on an expense-incurred basis.

(c) Discrimination prohibited. -- A policy or contract subject to this section may not discriminate against an individual with a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder by failing to provide benefits for the diagnosis and treatment of these illnesses under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illnesses.

From Vermont Code §4089b. Health Insurance Coverage; Mental Health and Substance Abuse

(a) As used in this section,

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402(7). Health insurance plan includes any health benefit plan offered or administered by the state, or any subdivision or instrumentality of the state.

(2) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

(3) "Rate, term or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible of out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

From Oregon 2005 Senate Bill 1 (ORS 743.556)

743.556. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

II. Definition of Covered Conditions

In many states, statute defines covered conditions and often limits coverage to the most serious mental illnesses. If not defined in statute, insurance plans have discretion to define covered conditions.

Key Points to Consider

- Does statute include substance abuse treatment for problems with alcohol and other addictive substances? A variety of terms may be used: alcoholism, substance abuse, substance use, chemical dependency.
- If your parity statute refers to mental illness, mental health disorder, mental health condition, mental or nervous condition, etc., is this term already defined in your state law? If not, then the term will need to be defined in the rule-making process (after legislation passes) or left up to insurance plans to define.
- In defining covered conditions, many states refer to conditions described in the Diagnostic and Statistical Manual of Mental Disorders (DSM), currently in its fourth (IV) edition and/or the International Classification of Disease (ICD), which is used internationally and is familiar to hospitals, primary care, etc. The ICD includes the same conditions as the DSM, with the exception of the "V" codes.
- The "V" codes in the DSM are mainly relational disorders (such as marital problems), but include three that specifically refer to children who are experiencing distress as a result of abuse, for example. These "V" codes are often used with very young children who, due to their age, cannot fit diagnostic criteria for a mental illness.
- Does the statute adequately provide coverage for serious early childhood disorders that do not fit diagnostic criteria in the DSM or ICD?
- Does statute allow for the most current version of the DSM or ICD to be used?
- Does the statute allow for coverage of mental health problems for individuals who are diagnosed with developmental disabilities? For persons with co-occurring mental health, substance abuse disorders, developmental disabilities, and/or other health conditions?

Example of Language from Existing Statute or Legislation

From Vermont Code §4089b. Health Insurance Coverage; Mental Health and Substance Abuse

(4) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

From Kentucky HB 268 (2000)

Section 1. A new section of subtitle 17A of KRS Chapter 304 is created to read as follows:

(1) "Mental health condition" means any condition or disorder that involves mental illness or alcohol and other drug abuse as defined in KRS 222.005 and that falls under any of the diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) or that is listed in the mental disorders section of the international classification of disease, or the most recent subsequent editions;

From Arkansas Act 1020 of 1997

Section 2. Legislative findings and intent.

It is the intent of this state that insurance coverage for mental illnesses and the mental health treatment of those with developmental disorders shall be as available and at parity with that for other medical illnesses.

Section 3. Definitions.

(5) “Mental illnesses” and “developmental disorders” mean those illnesses and disorders listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders.

III. Individual and Small Group Plans

Small group and individual exemptions are common in many states and serve to limit the number of individuals and families who benefit from parity.

Key Points to Consider

- The most comprehensive statutes are those that *do not* exempt individual or small group plans.

Example of Language from Existing Statute or Legislation

From Maryland Insurance Code Annotated §15-802 (2006)

§15-802. Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse

(b) Scope of section. This section applies to each health insurance policy or contract that is delivered or issued for delivery in the State to an employer or individual on a group or individual basis and that provides coverage on an expense-incurred basis.

From Vermont Code §4089b. Health Insurance Coverage; Mental Health and Substance Abuse

(a) As used in this section,

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402(7). Health insurance plan includes any health benefit plan offered or administered by the state, or any subdivision or instrumentality of the state.

IV. Financial and Durational Treatment Limits

In equitable parity laws, statutory language specifies that financial and durational treatment limits and cost-sharing must be equivalent to, and no more restrictive than, limits imposed on other health conditions and that specifies that deductibles or out-of-pocket limits are comprehensive for both mental heath and physical health conditions (e.g. no separate deductible).

Example of Language from Existing Statute or Legislation

From Vermont Code §4089b. Health Insurance Coverage; Mental Health and Substance Abuse

(a) As used in this section,

(3) "Rate, term or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

From Oregon 2005 Senate Bill 1 (ORS 743.556)

743.556. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

(2) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions.

From Connecticut Public Act No. 99-284, Sec. 27.

(b) No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.

From Kentucky HB 268 (2000)

Section 2.

(2) Expenses for mental health and physical health conditions shall be combined for purposes of meeting deductible and out-of-pocket limits required under a health benefit plan.

V. Medical Necessity

If physical health care coverage in a state can be denied if it is not medically necessary, then a parity law would likely and reasonably make coverage for mental health and substance abuse conditions subject to medical necessity criteria, as well.

Key Points to Consider

- It may be helpful to ensure that the term is defined in statute with one definition and in such a manner that promotes equitable access to care.

Example of Language from Existing Statute or Legislation

From Oregon Administrative Rule 836-053-1405

General Requirements for Coverage of Mental or Nervous Conditions and Chemical Dependency

(3) A group health insurance policy issued or renewed in this state must contain a single definition of medical necessity that applies uniformly to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

(4) A group health insurer that issues or renews a group health insurance policy in this state shall have policies and procedures in place to ensure uniform application of the policy's definition of medical necessity to all medical, mental or nervous conditions, and chemical dependency, including alcoholism.

From Arkansas Act 1020 of 1997

Section 5. Medical necessity.

This act shall not be construed as prohibiting a health benefit plan from excluding coverage for diagnosis and treatment of mental illnesses and developmental disorders when the diagnosis and treatment are medically unnecessary, provided that the medical necessity determination is made in accordance with generally accepted standards of the medical profession and other applicable laws and regulations.

The term "medical necessity" as applied to benefits for mental illnesses and developmental disorders means:

(1) reasonable and necessary for the diagnosis or treatment of a mental illness, or to improve or to maintain or to prevent deterioration of functioning resulting from such illness or developmental disorder;

(2) furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(3) the most appropriate level or supply of service which can safely be provided; and

(4) could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.

VI. Managed Care

Most statutes allow plans to use common managed care techniques such as the application of medical necessity, utilization review, and authorization or other practices.

Key Points to Consider

- Does statute require that managed care limitations or requirements be used only if similar limitations or requirements apply to other health conditions?
- Does statute ensure that a plan may not impose managed care requirements or limits in such a manner that is more restrictive or burdensome than for other health conditions (e.g. requiring prior authorization for all behavioral health services, but not for a visit to a pediatrician)?

Example of Language from Existing Statute or Legislation

From Oregon Administrative Rule 836-053-1405

(5) Coverage for expenses arising from treatment for mental or nervous conditions and chemical dependency, including alcoholism, may be managed through common methods designed to limit eligible expenses to treatment that is medically necessary only if similar limitations or requirements are imposed on coverage for expenses arising from other medical conditions. Common methods include, but are not limited to, selectively contracted panels, health policy benefit differential designs, preadmission screening, prior authorization of services, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary.

VII. Out-Of-Network Coverage

Many health plans provide coverage for out-of-network providers, typically with additional cost-sharing and/or authorization requirements.

Key Points to Consider

- Does statute require out-of-network provider coverage for mental health or substance abuse if offered for other health conditions? Does statute require that additional cost-sharing or other limitations or requirements be the same as those applied to out-of-network coverage for other health conditions?

VIII. Adequacy of Network Provider Panels

Without adequacy of network provider panels, a plan may offer a provider panel that does not include needed specialists, does not provide readily accessible providers, or does not provide well-qualified and appropriate providers.

Example of Language from Existing Statute or Legislation

Missouri HB 855 (2004) (The following language from Missouri's parity bill applies to mental health care provided through managed care organizations.)

The rules adopted shall assure that:

(a) Timely and appropriate access to care is available;
(b) The quantity, location, and specialty distribution of health care providers is adequate; and
(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

IX. Prescription Medications

Many states already have statutory provisions that provide for equivalent coverage of mental health medications. If not, consider language such as the following:

Example of Language from Existing Statute or Legislation

From Washington HB 1154

Sec 2.

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription rugs covered by the health benefit plan.

X. Specific Services for Serious Mental Illness

The National Business Group on Health, in *An Employer's Guide to Behavioral Health Services*, (http://www.businessgrouphealth.org/prevention/et_behavioralhealthreport.cfm) describes the historically limited nature of traditional treatment services and suggests a broadening of services to better serve those with serious mental illness.

From An Employer's Guide to Behavioral Health Services:
Part III, 5. Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness

a. Evidence-Based Treatment Modalities for the Seriously Mentally Ill

Problem: Historically, the scope of employer-sponsored benefits has been limited to traditional treatment services such as office-based professional services, partial hospitalization, and acute inpatient care. This benefit structure has been appropriate for many persons with mild to moderate impairment from their behavioral health disorders. However, employers provide healthcare coverage for a number of children and adults with serious mental illness and substance abuse disorders that have not responded to traditional treatment services. Fortunately, there are a number of evidence-based treatment programs designed for these populations. These programs have been in place for decades and have been paid for primarily by Medicaid and state mental health agencies. Numerous outcomes studies have demonstrated the effectiveness of these evidence-based treatment programs. Typically, these programs are intermediate level programs that deliver more intensive care than traditional outpatient services, but are less restrictive and less costly than inpatient care and have been shown to have better patient outcomes. In order for beneficiaries to gain access to these preferred evidence-based treatment modalities, employers need to 1) include these treatment modalities in their benefit plan, and 2) add to their network the appropriate providers and programs to deliver these services.

b. Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill

Recommendation: Employers should direct their MCOs or MBHOs to add providers that can deliver the above referenced evidence-based practices to their networks. Many of these providers primarily serve the public behavioral healthcare system (e.g. Medicaid) and may be better equipped to provide acute and long-term care for seriously and chronically ill children and adults.

Employers should supplement their existing inpatient provider network with facilities that have a range of 24-hour acute care and/or crisis programs tailored to seriously mentally ill children and adults. Some of these programs are operated by community mental health centers that may not be a part of employers' current networks.

From Arkansas Act 1020 of 1997 (This language identifies services that may be eligible for coverage under an insurance plan. This language would be strengthened if the statute were to require coverage for these services.) .

A health care insurer may at the insurer's option provide coverage for a health service, such as intensive case management, community residential treatment programs, social rehabilitation programs, clinical case management, 24-hour crisis care, and evidence-based treatment programs.

XI. Oversight of Implementation

Responsible agency regulation and oversight of parity implementation is important to ensure compliance with the intent and rule of parity statutes.

Key Points to Consider

- Does statute require agency to submit a comprehensive report that addresses potential concerns, such as reduced utilization of services?
- Does statute direct agency and plans to produce easy-to-understand literature outlining the new coverage offered under parity and how to easily access care?

Example of Language from Existing Statute or Legislation

From Act No. 25 of the 1997-1998 Vermont Legislature

Sec. 3. REPORT

On or before January 15, 1999, the Department of Banking, Insurance, Securities, and Health Care Administration shall report to the general assembly on the following:

(1) An estimate of the impact of this act on health insurance costs.

(2) Actions taken by the department to assure that health insurance plans are in compliance with this act and that quality and access to treatment for mental health conditions provided by the plans are not compromised by providing financial parity for such coverage.

(3) When a health insurance plan offers choices for treatment of mental health and substance abuse conditions as provided by 8 V.S.A. § 4089b(d), an analysis and comparison of those choices in regard to level of access, choice and financial burden.

(4) Identification of any segments of the population of Vermont that may be excluded from access to treatment for mental health and substance abuse conditions at the level provided by this act, including an estimate of the number of Vermonters excluded from such access under health benefit plans offered or administered by employers who receive the majority of their annual revenues from contract, grants or other expenditures by state agencies.

XII. Independent External Review of Claims

Typically, individuals who want to appeal a denial of coverage or exhaustion of coverage limits or other aspect of coverage must go through a plan's internal appeals process or processes. Some statutes or rules include provisions that allow an individual to go to independent external review for an unbiased final mediation of a disputed claim.

Example of Language from Existing Statute or Legislation

See Connecticut Public Act 99-284 (2002) for extensive consumer protection language.
http://www.cga.ct.gov/ps99/Act/pa/1999PA-00284-R00HB-07032-PA.htm

From Oregon Administrative Rule
Independent Review
836-053-1325
Procedures for Conducting Independent Reviews
(1) An independent review organization is subject to the following decision-making standards and procedures:
(a) The independent review process is intended to be neutral and independent of influence by any affected party or by state government. The Director may conduct investigations as authorized by law but has no involvement in the disposition of specific cases.
(b) Independent review is a document review process. An enrollee, a health plan or an attending provider may not participate in or attend an independent review in person or obtain reconsideration of a determination by an independent review organization.
(c) An independent review organization shall present cases to medical reviewers in a way that maximizes the likelihood of a clear, unambiguous determination. This may involve stating or restating the questions for review in a clear and precise manner that encourages yes or no answers.
(d) An independent review organization may uphold an adverse determination if the patient or any provider refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond. An independent review organization may overturn an adverse determination if the insurer refuses to provide relevant medical records that are available and have been requested with reasonable opportunity to respond.
(e) An independent review organization must maintain written policies and procedures covering all aspects of review.
(2) Once the Director refers a dispute, the independent review organization must proceed to final determination unless requested otherwise by both the insurer and the enrollee.
(3) An independent review organization is subject to the following standards with respect to information to be considered for reviews:
(a) An independent review organization must request as necessary and must accept and consider the following information as relevant to a case referred:
(A) Medical records and other materials that the insurer is required to submit to the independent review organization under ORS 743.857(3), including information identified in that section that is initially missing or incomplete as submitted by the insurer.
(B) For cases in which the insurer's decision addressed whether a course or plan of treatment was medically necessary:
(i) A copy of the definition of medical necessity from the relevant health insurance policy;
(ii) An explanation of how the insurer's decision conformed to the definition of medical necessity; and
(iii) An explanation of how the insurer's decision conformed to the requirement

that the definition of medical necessity be uniformly applied.
(C) For cases in which the insurer's decision addressed whether a course or plan of treatment was experimental or investigational:
(i) A copy of the definition of experimental or investigational from the relevant health insurance policy;
(ii) An explanation of how the insurer's decision conformed to that definition of experimental or investigational; and
(iii) An explanation of how the insurer's decision conformed to the requirement that the definition of experimental or investigational be uniformly applied.
(D) Other medical, scientific and cost-effectiveness evidence, as described in subsection (4) of this section, that is relevant to the case.
(b) After referral of a case, an independent review organization must accept additional information from the enrollee, the insurer or a provider acting on behalf of the enrollee or at the enrollee's request, but only if the information is submitted within seven days of the referral or, in the case of an expedited referral, within 24 hours. The additional information must be related to the case and relevant to statutory criteria.
(c) An independent review organization must ensure the confidentiality of medical records and other personal health information received for use in reviews, in accordance with applicable federal and state laws.
(4) If a course or plan of treatment is determined to be subject to independent review, a determination of whether the adverse decision of an insurer should be upheld or not must be based upon expert clinical judgment, after consideration of relevant medical, scientific and cost effectiveness evidence and medical standards of practice in the United States. As used in this section:
(a) "Medical, scientific, and cost-effectiveness evidence" means published evidence on results of clinical practice of any health profession that complies with one or more of the following requirements:
(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
(B) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR);
(C) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
(D) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
(E) Findings, studies or research conducted by or under the auspices of a federal government agency or a nationally recognized federal research institute, including the Federal Agency for Healthcare Research and Quality, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Center for Medicaid and Medicare Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services;
(F) Clinical practice guidelines that meet Institute of Medicine criteria; or
(G) In conjunction with other evidence, peer-reviewed abstracts accepted for presentation at major scientific or clinical meetings.
(b) Medical standards of practice include the standards appropriately applied to physicians or other providers or health care professionals, as pertinent to the case.
(5) The following standards govern the assignment by an independent review organization of appropriate medical reviewers to a case:
(a) A medical reviewer assigned to a case must comply with the conflict of interest

provisions in OAR 836-053-1320.
(b) An independent review organization shall assign one or more medical reviewers to each case as necessary to meet the requirements of this subsection. The medical reviewer assigned to a case, or the medical reviewers assigned to a case together, must meet each of the following requirements:
(A) Have expertise to address each of the issues that are the source of the dispute.
(B) Be a clinical peer. For purposes of this paragraph, a clinical peer is a physician or other medical reviewer who is in the same or similar specialty that typically manages the medical condition, procedures or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category, as the attending provider. In a profession that has organized, board-certified specialties, a clinical peer generally will be in the same formal specialty.
(C) Have the ability to evaluate alternatives to the proposed treatment.
(c) Each independent review organization must have a policy specifying the methodology for determining the number and qualifications of medical reviewers to be assigned to each case. The number of reviewers shall be governed by what it takes to meet the following requirements:
(A) The number of reviewers must reflect the complexity of the case and the goal of avoiding unnecessary cost.
(B) The independent review organization may consider, but shall not be bound by, recommendations regarding complexity from the insurer or attending provider.
(C) The independent review organization shall consider situations such as review of experimental and investigational treatments that may benefit from an expanded panel.
(6) An independent review organization shall notify the enrollee and the insurer of its determination of the enrollee's case and provide documentation and reasons for the determination, including the clinical basis for the determination unless the decision is wholly based on application of coverage provisions. In addition:
(a) Documentation of the basis for the determination shall include references to supporting evidence, and if applicable, the reasons for any interpretation regarding the application of health benefit plan coverage provisions, but shall avoid recommending a course of treatment or otherwise engaging in the practice of medicine.
(b) If the determination overrides the health benefit plan's standards governing the coverage issues that are subject to independent review, the reasons shall document why the health benefit plan's standards are unreasonable or inconsistent with sound, evidence-based medical practice.
(c) The written report shall include the qualifications of each medical reviewer but shall not disclose the identity of the reviewer.
(d) Notification of the determination shall be provided initially by phone, e-mail or fax, followed by a written report by mail. In the case of expedited reviews, the initial notification shall be immediate and by phone, followed by a written report.
(7) Except as provided in this section, an independent review organization shall not disclose the identity of a medical reviewer unless otherwise required by state or federal law. The Director shall not require reviewers' identities as part of the contracting process but may examine identified information about reviewers as part of enforcement activities. The identity of the medical director of an independent review organization shall be disclosed upon request of any person.
(8) An independent review organization shall promptly report any attempt at interference by any party, including a state agency, to the Director.
(9) An independent review organization must maintain business hours, methods of contact (including telephone contact), procedures for after-hours requests and other relevant procedures to ensure timely availability to conduct expedited as well as regular reviews.

836-053-1330
Criteria and Considerations for Independent Review Determinations
(1) The following criteria and considerations apply to determinations by an independent

review organization:
(a) An independent review organization must use fair procedures in making a determination, and the determination must be consistent with the standards in ORS 743.862 and OAR 836-053-1300 to 836-053-1365.
(b) An independent review organization may override the standards of a health benefit plan governing the coverage issues that are subject to independent review pursuant to ORS 27 743.857(1) only if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.
(2) A determination by an IRO of a dispute relating to an adverse decision by an insurer is subject to enforcement under ORS 743.857 to 743.864 if:
(a) The dispute relates to an adverse decision on one or more of the following:
(A) Whether a course or plan of treatment is medically necessary;
(B) Whether a course or plan of treatment is experimental or investigational; or
(C) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854; and
(b) The decision by the independent review organization is made in accordance with the coverage described in the health benefit plan, including limitations and exclusions expressed in the plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment, if the independent review organization determines that**:**
(A) The standards of the insurer are unreasonable or are inconsistent with sound medical practice**;** or
(B) For cases in which the insurer’s decision addressed whether a course or plan of treatment was medically necessary:
(i) The insurer’s decision did not conform to the insurer’s definition of medically necessary in the relevant health insurance policy, or

(ii) The insurer’s decision did not conform to the requirement that the definition of medical necessity be uniformly applied; or
(C) For cases in which the insurer’s decision addressed whether a course or plan of treatment was experimental or investigational:
(i) The insurer’s decision did not conformed to the insurer’s definition of experimental or investigational in the relevant health insurance policy, or
(ii) The insurer’s decision did not conform to the requirement that the definition of experimental or investigational be uniformly applied.