SENATE BILL 1646 | SEN. TODD GOLLIHARE AND REP. MARK LAWSON

Establishing fair standards for behavioral health care coverage

HEALTHY MINDS POLICY INITIATIVE

Insurance companies have significant power to determine the type of behavioral health care a person receives and what it costs. But **many insurers make these life-changing determinations using vague and arbitrary standards for coverage that often conflict with evidence-based clinical guidelines** — taking decisions out of the hands of health care providers who know their patients' needs best. SB 1646 would require commercial insurance providers to adopt generally accepted standards of mental health and substance use disorder care to decide whether to cover a given service or treatment.

Defining the problem

- When coverage for mental health and substance use disorder services are denied, patients can get worse, which forces them into more expensive, inappropriate levels of care
- Republicans and Democrats alike strongly support requiring insurers to use transparent, evidence-based guidelines from independent medical experts when making coverage decisions, according to independently led focus groups in Oklahoma City in 2024

Who sets generally accepted standards of care?

- "Generally accepted standards of care" for mental health and substance use disorders refers to **evidence-based criteria that are created, endorsed, and recognized by behavioral health experts** about what type of treatment works for people in a given scenario
- Under SB 1646, insurance companies would have to use these criteria to make determinations about what care is medically necessary — and therefore what care gets covered
- Experts rely on evidence-based guidelines like the American Society for Addiction Medicine (ASAM) criteria, peer-reviewed academic studies, medical literature, and others to establish generally accepted standards of care

Streamlining care through fair standards

- When insurance companies use clinically sound standards to make care decisions, patients often have better care outcomes and experience a fairer, simpler way of accessing treatment for mental health and substance use conditions
- For example, insurers might use arbitrary time limits to cap the number of days someone can spend in inpatient care; using generally accepted standards of care, decisions about the right level of care are grounded in evidence and recommendations from a patient's care team

One-sixth

of all medical necessity denials involved behavioral health services[1] despite representing only **5% of health care spending**[2]

29%

of respondents to a national survey reported being **denied mental health care** — more than twice the rate of other medical services[3]

$38B

estimated annual savings from effective behavioral health treatment[4]

1: KFF, 2023

2. Milliman, 2019

3: National Alliance on Mental Illness, 2015

4. Milliman, 2018