HB 4028 Testimony

Thank you, Chair Pham, Vice-Chairs Edwards and Javadi, and members of the committee. My name is Patrick Mooney and I am a psychologist member of the Oregon Independent Mental Health Professionals (OIMHP) legislative committee. I am testifying in support of HB 4028. Today, I would like to describe parity reporting requirements this bill will offer to help state regulators determine insurers' mental health parity compliance.

Section 7 of HB 4028 describes specific types of "medical management" non-quantitative treatment limitations (NQTLs), that insurers have applied either in Oregon or in other states, which have the potential to be applied more stringently to behavioral health than to physical health benefits. This, of course, would be a violation of federal and state mental health parity laws. NQTLs are defined as non-numeric health benefit restrictions (meaning they can't be easily quantified by number of visits, days, or units of service) which limit the scope or duration of healthcare treatment.

Federal and state agencies' efforts to assess parity compliance are difficult to accomplish. DCBS must navigate several challenges in order to review and assure NQTL medical management parity in accordance with their regulatory responsibilities:

- First, there is **no finite or exhaustive list of medical management NQTLS** that describe what insurers must report to regulators to assure compliance. The federal parity rules left this open-ended because new methods of medical management would always be emerging. Think about the recent explosion of A.I.
- Because insurers must **self-report** NQTLS, there is always the possibility that they will fail to identify their medical management strategies, either by error of omission or by intent.
- True parity compliance must include not only a written description of each medical management strategy, but also how these management strategies bring about parity compliance **"in operation"**. For example, it's not enough for an insurer to say they perform the same type of utilization review of both behavioral health (BH) and medical office visit records; they must give **details** about how they do this and how doing so does not have an adverse effect upon mental health professional service delivery.

In the most recent 2025 MH parity report by DCBS, their fourth report since 2022, they wrote:

> *Many insurers continue to fall short in providing "in operation" analysis for important NQTLs, such as provider reimbursement rates, concurrent review, and provider network admission. In several instances, insurers were unable to demonstrate, with specific examples or evidence, that policies and procedures are applied comparably across benefit types. This ongoing lack of transparency and standardized reporting makes it difficult to evaluate and ensure parity in real-world application.*

We believe insurers need more direction about the specific types of medical management they must report. The specific HB 3046 (2021) requirement for insurers to report provider reimbursement methodology, and how insurers' annual rates compared to a regional percentage of Medicare rates, improved parity compliance. The results were:

- Most insurers now pay both physical and BH disciplines using the same methodology;
- BH provider rates have increased significantly over recent years,
- More BH providers are now willing to participate on insurance panels. Specific reporting directives decreased the percentage of BH out-of-network claims from approximately 15% in 2021 to roughly 5% in 2024. This now closely mirrors physicians' 4% out-of-network claim percentage
- So now, more Oregonians have greater access to insurance-based affordable BH care.

Section 7 of HB 4028 specifies medical management reporting requirements and should help provide DCBS with more detail about how insurers manage care. Our expectation is that this increased specificity will:

- increase transparency,
- enhance DCBS's ability to assess MH parity compliance,
- persuade insurers to voluntarily stop using punitive strategies to restrict BH care, and
- increase therapists' willingness to join and stay within insurance provider networks.

HB 4028's Section 7 (4) further requires insurers to report directly to BH providers when they are applying specific medical management procedures to providers' practices. This section also requires insurers to attest that these BH medical management procedures are being applied equivalently to their medical providers. Rather than a once and done annual reporting to DCBS, this section of 4028 would require **on-going, real-time operational reporting** of mental health parity compliance. So, if insurers' annual reporting falls short in identifying all of their NQTL medical management processes, medical management reporting to providers should identify their parity operations **in action**.

We hope your committee will vote to pass HB 4028.