February 3, 2026

Representative Hai Pham, Chair
Representative Darcey Edwards, Vice-Chair
Representative Cyrus Javadi, Vice-Chair
House Committee on Behavioral Health
900 Court Street NE
Salem, OR 97301

Delivered electronically.

Re: Opposition to House Bill 4028 (2026)

Chair Pham, Vice-Chairs Edwards and Javadi, and members of the committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 600,000 commercial, Medicaid, and Medicare Advantage members in three states. PacificSource Community Solutions is the contracted coordinated care organization (CCO) in Central Oregon, the Columbia River Gorge, and Marion & Polk Counties. Our mission is to provide better health, better care, and better value to the people and communities we serve.

We write in opposition to House Bill 4028, a bill that we have opposed in 2023 as House Bill 2455 and in 2025 as House Bill 2029. From the outset, we note that we too want to ensure a balance between our provider partners' administrative burden and our responsibilities to the state and federal government (not to mention our members) to limit fraud, waste, and abuse. However, we believe that House Bill 4028 moves the pendulum too far away from ensuring program integrity and accountability.

First, though, we wish to address how the process works in PacificSource. Our compliance and program integrity plan that apply to commercial health benefit plans look to Medicare standards:

- After receiving a complaint or through a random sampling, we request medical records for members, or for a date range.
- We make available an electronic portal for ease of submitting information. Providers have 30 calendar days to supply records.
- If the records received from the provider support the claims made, no further action is necessary. If records do not support the claims audited, then we may need to take further action (e.g., denying similar future claims, provider education, recoupment).

We ensure to make freely available to our provider partners a comprehensive manual that outlines, among other things, procedures on program integrity.[1] Our manual outlines examples of fraud, waste, and abuse as well as outlines the process of undertaking program integrity audits with providers. We feel that a separate document setting out these standards (of which failing to disclose bars us from engaging in reasonable auditing standards) is at best unnecessary.

To our concerns with the bill, we are unclear to what extent federal law would preempt application of the bill to the Oregon Health Plan. Medicaid payment integrity rules[2] and corresponding CCO contract requirements[3] require coordinated care organizations to implement and maintain procedures designed to detect and prevent fraud, waste, and abuse. These rules require managed care organizations (like Oregon's CCOs) to adopt provisions for prompt reporting of all overpayments identified and recovered, especially those that specify overpayment due to fraud. Federal regulations specifically require that CCOs verify, through sampling or other methods, whether services were received by our members on a regular basis.[4] The Oregon Health Authority (OHA) Program Integrity Unit also performs audits on providers, which are generally conducted in synchronization with coordinated care organization audits. OHA regulations also require random sampling of claims to detect and deter fraud, waste, and abuse.[5] Sampling only when there is a high probability of an error, as HB 4028 provides, undermines the point of random sampling.

Second, we note that Oregon's Insurance Code already places conditions on how commercial health benefit plans may recoup claims paid to providers.[6] The limited conditions under which commercial health benefit plans may recoup claims have an exception for fraud, waste, and abuse. House Bill 4028 would likely conflict with and limit existing law applicable to commercial insurers. Since this bill does not repeal the existing standards, we will have two different standards for behavioral health providers and for physical health providers. This will be administratively burdensome for providers who provide care in both settings. Complexity adds, time, cost, and abrasion that no one wishes to experience in the claims process.

This bill, like legislation introduced before it, prohibits health plans from recouping reimbursement in the case of "clerical errors," which are defined in the base bill as "minor error[s] in the keeping, recording or transcribing of records or documents or in the handling of electronics or hard copies of correspondence." Clerical errors may be isolated instances or could occur in a pattern of conduct that could point to potential fraud, waste and abuse in the claims process. Simply characterizing all clerical errors as harmless and exempt further limits health plans' abilities to deter fraud.

Thus, limiting the ability for health plans to deter and detect fraud, waste, and abuse inconsistent with federal standards creates risks for health plans and may lead to higher premiums paid by individuals and small businesses.

Our recommendation, if the committee does decide to move forward with the bill, is to align standards across lines of insurance (commercial and Medicaid) with Medicare program integrity rules for addressing fraud, waste, and abuse.

The 2026 legislation before this committee adds new reporting requirements to a statute, ORS 743B.427, which seeks to incorporate federal mental health reporting requirements into Oregon's Insurance Code. This current bill only applies reporting requirements to fully insured health plans, which extend to about 23% of Oregonians in the state. Plans covered by the

[1] https://pacificsource.com/sites/default/files/2023-03/PRV1_0323_ProviderManual.pdf
[2] *See* 42 CFR § 438.608.
[3] 2023 contract template available at https://www.oregon.gov/oha/HSD/OHP/CCO/2023-CCO-Contract-Template.pdf
[4] 42 CFR § 438.608(a)(5).
[5] OAR 407-120-1505(8).
[6] ORS 743B.451

Employment Retirement Income Security Act of 1974, as amended, as well as Medicaid and Medicare do not have to report on this data. We fail to understand what the new reporting requirements purport to achieve, as is evident from the draft commercial plans already report voluminous data to the Department of Consumer and Business Services.

Finally, the bill makes all the provisions effective 91 days after adjournment sine die. The rule writing and administrative tasks alone that will be necessary for the state to implement the law could not be accomplished within 91 days. The speed at which this bill demands compliance underestimates all the work that will be needed by the Department of Consumer and Business Services, the Oregon Health Authority and commercial and government payers to implement this bill, should it pass.

For these reasons, we respectfully oppose this legislation. We would, as we have in sessions past, like to instead work with the proponents before a bill is introduced to determine how to limit where practicable the impact of auditing requirements on small businesses, while limiting the impact on smaller, not-for-profit health plans like PacificSource.

Thank you for your consideration. Please do not hesitate to contact me at richard.blackwell@pacificsource.com with questions or concerns.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations