Regence | 200 SW Market Street, 11th Floor
Portland, OR 97201

Testimony on HB 4028: Behavioral Health Audits

February 3, 2026

Chair Nosse and Members of the Committee,

My name is Mary Anne Cooper, and I am the Oregon Director of Public Affairs Regence BlueCross BlueShield of Oregon. As the state's largest health insurer, Regence is committed to addressing both persistent and emerging health needs for the nearly one million Oregonians we serve. In keeping with our values as a tax paying nonprofit, 90% of every premium dollar goes to pay our members' medical claims and expenses.

I want to start by acknowledging the incredible work that our behavioral health professionals do every day for all of us. We know the last several years have been uniquely challenging, and we really appreciate them showing up every day for our members. At Regence, we have been working hard during this time to maintain a broad and robust provider network for our members, and a significant part of that work is ensuring that providers want to participate in our network. We know it can be intimidating to be audited by insurance companies, and we want to ensure our audit practices are transparent and workable for providers.

As an insurer, we have an obligation to the nearly one million Oregonians that we serve to be good stewards of their dollars and ensuring that billing is correct and accurate is an important part of fulfilling that obligation. We have information on our claims submission and audit practices available for our providers on our website. We follow the Centers for Medicare & Medicaid Services (CMS) regulations and guidance on correct billing and coding use.

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We weren't aware HB 4028 was being reintroduced this session, but recently shared proposed changes with proponents. While these changes were not considered in prior years, we hope these suggestions will be considered this year, as aligning audit standards across all lines of business benefits both providers and payers. Inconsistent requirements create administrative burden and can increase costs for consumers.

HB 4028 would make significant changes to existing audit practices and would be challenging to operationalize due to the following technical issues that we would appreciate working with the proponents to resolve:

1. Scope of Entities

We appreciate the narrower scope of entities covered by the bill. However, our claims processing systems cannot differentiate between small and large providers and apply separate standards accordingly – we contract and process claims by Tax ID, regardless of size. For example, the current draft would prevent us from recouping clerical errors for smaller providers. Our system catches these errors (such as duplicate claims submitted on the same day for the same service) and processes only one claim.

While this isn't an audit in the traditional sense, the definition in the bill is unclear about this situation, which is common. If we can't configure different rules for different provider sizes and those changes are considered an "audit", we may need to apply this change system-wide—potentially beyond behavioral health claims—which would result in a significant price tag for consumers on clerical errors alone. This is something we need to work through to ensure the bill is only catching traditional post-claims processing audits, and not correction of errors and claims processing that occurs when the

claim is submitted. This would also enable us to ensure we can implement to the targeted providers, as we'd only be talking about traditional insurer-initiated post claims audits.

2. Mental Health Parity (MHP) Reporting Changes

The proposed MHP reporting changes are brand new, and raise a significant and complex issue for a short session. We have two primary concerns:

- Medical Management Definition: Adding "medical management" and its examples to the NQTL definition may create confusion, as many medical management components already qualify as NQTLs under existing regulations. This could make it difficult for carriers to understand expectations and for agencies to ensure consistent reporting.
- Scope Beyond Parity Intent: The bill introduces audits and payment clawbacks that extend beyond Mental Health Parity law's original purpose—ensuring members receive behavioral health care that's no more restrictive than medical/surgical care. This legislation appears to regulate provider contracting terms under the parity framework, which conflates member access protections with provider business arrangements.

Multiple MH Parity regulations that deviate from federal standards will increase administrative burden and costs for consumers—something I'm sure we all want to avoid.

Regarding the new medical policies sections: we can share Regence-developed policies, but LOCUS/CALOCUS/ASAM have sharing restrictions, and these govern most of our behavioral health medical policies. As such, this section will be impossible to implement without amendments.

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3. Additional Technical Issues

- As mentioned above, it appears that much of what is captured both under the broad provisions of the bill and the definition of the term "audit" are potentially presently part of our day-to-day controls on our claims payment processes, versus a formal audit of claims associated with a specific provider.
- We also do not believe it is appropriate to restrict recoupment based on a clerical error. If a provider bills in error, we should be able to recoup costs paid in error.
- We also have concerns about the restriction on bringing a new audit of a claim while another audit is in the process. Different audits can be conducted for different issues, and especially given the strict timeframes in the bill, multiple audits may need to occur at one time.
- Additionally, we have questions about how this will work with the Federal Employee Program and other federal contracts which have their own audit rules and requirements. When audits are required by third parties, we have to meet their audit terms and conditions, which may not align with this bill.
- Finally, the state and the industry have been trying to streamline and support parity between behavioral health and medical health care. Having different audit standards could create significant operational challenges that further segment the two types of services and run counter to our goals to integrate and streamline behavioral health and medical healthcare as much as possible.
- Oregon's Insurance Code already places a number of restrictions on how commercial health benefit plans may recoup claims paid to providers. It's unclear to me whether the issues raised by providers are part of the state regulated market, or occurring in other lines of business that are not state regulated.

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4. Path Forward

Each time this bill has been introduced, we've requested a workgroup or collaborative process with proponents to find common ground that addresses concerns without adding unnecessary complexity or costs. We'd welcome the opportunity to participate in an interim workgroup with Rep. Harbick and other stakeholders on this topic.

Please do not hesitate to contact me if you have any questions.

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