PacificSource
HEALTH PLANS

February 6, 2026

Senator Khanh Pham, Co-Chair
Representative Nancy Nathanson, Co-Chair
Oregon Legislative Assembly
Joint Committee on Information Management and Technology
900 Court St. NE
Salem, OR 97301

Delivered via OLIS and email.

Re: Opposition to House Bill 4054

Co-Chairs Pham and Nathanson, and Members of the Joint Committee:

The PacificSource companies are independent, not-for-profit health insurance providers based in Oregon. We serve over 500,000 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 to express our strong opposition to House Bill 4054, a health care bill relating to the use of software tools in the prior authorization process. Because this committee rarely hears health care bills, we would like to talk briefly about the statute the bill seeks to amend, ORS 743B.423. This statute governs how health plans carry out utilization reviews, both prior to the provision of health care services and, more importantly for this bill, post-claims review. Key attributes of existing law include:

- Written denials must include specific reasons, cite policy language, and be based on peer-reviewed, evidence-based literature.
- Health plans must use evidence-based, up-to-date criteria, including for delegated reviews.
- Providers must already be given the opportunity for a timely appeal of denied services to a medical consultant or peer review committee.
- Health plans must submit annual summaries of their utilization review policies and procedures to the Department of Consumer and Business Services (DCBS).
- A licensed physician must be responsible for final recommendations on medical necessity or appropriateness of services.

Utilization management, like much of insurance, is heavily regulated for the health plans covered by the state's Insurance Code. This Assembly has devoted much time and effort to passing prior authorization and utilization management bills since 2019.

- In 2019, the Assembly enacted Senate Bill 249,[1] which established clearer timelines for prior authorization requests – a carrier must respond to nonemergent requests within two business days and must answer within fourteen days if the carrier requests more time to make a decision. The Act also prohibited insurers from engaging in a pattern or practice of denials without just cause and added prior authorization practices to the unlawful claims settlement practices act.

- In 2021, the Assembly enacted House Bill 2517,[2] a more sweeping bill that required reporting to DCBS on prior authorization data, modified the appeals and grievance process to ensure that independent reviews be conducted by a clinician who is of the same type who prescribed the treatment, requires plans to post information on what treatments are subject to review, limits how often we can change criteria, and made many changes to step therapy and utilization management of drugs.

- In 2025, the Assembly enacted House Bill 3134, which codifies federal requirements around interoperability and requires reporting to the Department of Consumer and Business Services on denials and other statistics consistent with Medicare rules.

The point of reciting this legislative history is to underscore the delicate balance the Assembly must strike when making changes to the utilization management process. The process is one of checks and balances. Health plans should not be using the utilization management process to simply deny care it promised to deliver through access. Similarly, providers must also submit accurate and truthful claims for reimbursement that reflect the services rendered to one of our members. Payment integrity efforts matter to ensure that members receive the right care at the right time, and conserve finite health care resources.

In the technological arms race to develop "artificial intelligence," health systems and providers are also utilizing software tools that pose legal and compliance risks. Sometimes, the deployment of those tools by health systems leads to significant legal jeopardy. For instance, in November 2024, University of Colorado Health paid $23 million to settle a federal False Claims Act lawsuit alleging that the health system improperly used software tools to inflate hospital emergency department claims.[3] As the technology matures and prices for software suites drop, these capabilities will be available to ever-smaller practices.

Rather than pass this bill this session, we envision the need to develop a robust governance framework to solve how all health care participants can leverage these potential powerful and time-saving automated tools to get to "yes" in claims and billing without upending the delicate checks and balances of provider-payer relationships. The demand for health care is not decreasing anytime soon, and all the system partners in health care will need to augment their existing capabilities and duties. But we should regulate that augmentation responsibly and equitably. Unfortunately, HB 4054 tilts the balance in favor of providers who may be unknowingly deploying "black-box" algorithms without any check by the health plan.

We also see some technical challenges with the text of the legislation, as introduced:

- In proposed paragraph (i), the new provision applies when an insurer uses "an artificial intelligence, algorithm or other software tool[.]" Without definitions, the

[1] 2019 Or Laws ch 284.
[2] 2021 Or Laws ch 154.
[3] https://www.justice.gov/archives/opa/pr/uchealth-agrees-pay-23m-resolve-allegations-fraudulent-billing-emergency-department-visits

reader is left to figure out which kinds of systems create compliance requirements. Under the National Artificial Intelligence Initiative, a federal law passed in 2021, artificial intelligence is defined as "[a] machine based system that can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments."[4]

More problematically, an algorithm, in its common meaning, is simply a "step-by-step procedure for solving a problem or accomplishing some end." Modern software is built on rules, so this could capture a broad swath of billing software used today even if not conventionally thought of as "artificial intelligence." Unclear compliance requirements add cost, complexity and can lead to unnecessary and expensive examinations or other compliance activities.

- The draft requires that anytime "a claim" is adjusted with a software tool, the health plan must deliver a notice that includes certain disclosures. It is not clear from the draft that health plans can treat notices and appeal rights collectively, or if each claim creates a separate notice and a separate appeal process. This creates a difficult choice for the plan: either repeat a cumbersome process multiple times for the same provider, or refrain from using automated tools. For a bill that purports to seek only transparency, this provision appears more prohibitory in nature.

For those reasons, we respectfully oppose HB 4054. We would ask that the committee table this legislation and think more holistically about how new and powerful technologies can help the healthcare system as a whole.

Please do not hesitate to contact me at richard.blackwell@pacificsource.com with questions or concerns.

Sincerely,

/s

Richard Blackwell
Director, Oregon Government Relations

[4] 15 USC § 9401, Pub. L. 116-283 (2021).