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

Regence Testimony in Opposition to House Bill 4054

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

Thank you for the opportunity to testify today in opposition to HB 4054. My name is Mary Anne Cooper, and I am the Director of Government Affairs at Regence BlueCross BlueShield of Oregon. As the state's largest health insurer, Regence serves nearly 1 million Oregonians. As a tax-paying nonprofit, 90% of every premium dollar pays for our members' medical claims and expenses.

We share the legislature's commitment to transparency in claims processing. However, this issue has not previously been raised with the legislature, was developed without any stakeholder or collaborative process that would have provided the opportunity for feedback, and HB 4054 does align with existing national standards. The legislature should direct proponents to work with insurers in the interim to develop a concept that meets their goals without creating Oregon-specific requirements that would undermine interoperability and ultimately increase member premiums.

Committed to payment integrity and transparency

Health insurers process millions of claims per year. To do so efficiently and accurately, payment integrity software—incorporating human-designed, rules-based algorithms—is used to review claims and ensure accuracy. This software serves critical functions: it ensures members are only billed for services they actually received, enables timely payment to providers, and helps identify fraud, waste, and abuse that drive up costs for everyone. **At Regence, 92% of claims in our fully-insured market are paid as billed without any adjustments.** For the remaining claims that require adjustment, we use nationally standardized systems to communicate those changes transparently.

While we understand the bill's goal of transparent AI use, hospitals are adopting AI far more rapidly than insurers. In 2025, health systems account for 27% of AI adoption among health care entities compared to just 14% for payers nationally. **This disparity is even starker in investment: health**

systems have invested $1 billion in AI versus payers' $50 million[1]. These investments are paying off—one health system in Nebraska recently reported generating over $2 million in gross revenue through AI-enabled automated claims systems[2]. Given that providers are adopting AI tools at substantially higher rates than payers, transparency standards should apply equally to both.

Why accurate coding matters

Accurate coding directly impacts what Oregon families pay for health care. When services are coded at higher complexity levels than warranted, members face higher costs immediately and those inflated costs eventually drive-up premiums for everyone.

The financial impact of coding inconsistences is substantial and growing. Nationally, coding of emergency department visits at the highest complexity level jumped from 16% of all ED visits in 2011 to 25% in 2021—a 56% increase in just one decade[3]. **A study analyzing claims from five states found that coding inconsistencies led to $14.6 billion in overpayments** to hospitals in 2019 across commercial, Medicaid, and Medicare payers[4].

Coding inconsistencies can happen for many reasons and are not always intentional. But regardless of cause, the financial burden falls on members. As stewards of member premium dollars, carriers have a responsibility to ensure members are only charged for the services they actually receive. Payment integrity processes serve this essential function, preventing individual members from facing inappropriate charges while keeping premiums affordable for all Oregonians.

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[1] Menlo Ventures. (2025). *2025: The state of AI in healthcare*. https://menlovc.com/perspective/2025-the-state-of-ai-in-healthcare/

[2] Bill Siwicki. Feb. 5, 2025. *Nebraska Methodist gains $2 million with AI-assisted coding*. https://www.healthcareitnews.com/news/nebraska-methodist-gains-2-million-ai-assisted-coding

[3] Outpatient visits billed at increasingly higher levels: implications for health costs - Peterson-KFF Health System Tracker. (2024, July 8). Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/outpatient-visits-are-increasingly-billed-at-higher-levels-implications-for-health-costs/#Share%20of%20outpatient%20office%20claims%20by%20level

[4] Crespin, D., Dworsky, M., Levin, J., Ruder, T., & Whaley, C. (2024). Upcoding Linked To Up To Two-Thirds Of Growth In Highest-Intensity Hospital Discharges In 5 States, 2011–19. In Health Affairs. https://www.nihcr.org/wp-content/uploads/crespin-et-al-2024-upcoding-linked-to-up-to-two-thirds-of-growth-in-highest-intensity-hospital-discharges-in-5-states_compressed.pdf

National standards already ensure transparency

Carriers already use nationally standardized Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) to communicate why any claim has been adjusted. These codes are not created by individual carriers, but are developed and maintained by X12, a standards organization affiliated with the Centers for Medicare and Medicaid Services[5]. This means every payer in the country—including Medicare, Medicaid, and all commercial insurers—uses the same codes to communicate the same information.

When a claim is adjusted, these standardized codes are assigned during adjudication and appear on the remittance advice sent to providers. They explain the reason for the adjustment and direct providers to carrier websites where they can access detailed medical policies and claims appeal processes. **This framework ensures consistent, clear communication across the entire health care system, whether a provider is working with Regence, Medicare, or any other payer.**

Ensuring interoperability and effective transparency

HB 4054 would require carriers to indicate whether AI or automated software was used in claim adjustments. While we understand the intent, this requirement creates significant problems:

- **No such code exists in the national standard.** X12 maintains the standardized code system, and there is currently no code to indicate whether software was used in identifying a claim adjustment. Creating this code would require X12 approval, and it's unclear whether they would support Oregon's approach.
- **Carrier-specific solutions would undermine transparency.** If every carrier creates its own method for indicating software use, it defeats the purpose of standardized codes. Providers would need to learn different systems for different payers, reducing rather than enhancing clarity.
- **The distinction may not be meaningful.** The existing CARC/RARC codes already explain *why* a claim was adjusted. Whether that adjustment was identified by software or manual review, the reason

[5] X12. (n.d.). *Codes*. https://x12.org/codes

for the adjustment—and the provider's ability to understand and appeal it—remains the same.

Exclusion of the state plan

We strongly oppose the -1 amendment exempting state plans (OEBB and PEBB) from requirements imposed on commercial insurers. The state cannot mandate costs for private insurers and Oregon families while exempting itself—this creates an unfair double standard. This amendment prioritizes avoiding fiscal impact over sound policy. If these requirements are too costly for state employee plans, they're too costly for all Oregonians.

Recommended path forward

We respectfully request that the legislature not move forward HB 4054, and instead direct proponents to work with insurers in the interim to develop a concept that meets their goals without creating Oregon-specific requirements that would undermine interoperability and ultimately increase member premiums.

Conclusion

Regence shares the legislature's commitment to transparency in the health care system. We want to work with the committee, providers, and other stakeholders to achieve transparency in a way that works for all Oregonians.

We respectfully urge you to direct proponents to come to the table in the interim to build on the national standards that already provide clear, consistent communication rather than creating requirements that would fragment the system and increase costs for members.

Mary Anne Cooper, MaryAnne.Cooper@CambiaHealth.com