A-Engrossed
House Bill 4028

Ordered by the House February 16
Including House Amendments dated February 16

Sponsored by Representatives HARBICK, NOSSE; Representatives BOICE, BUNCH, MARSH, OWENS, PHAM H, RIEKE SMITH, SKARLATOS, WALTERS, Senator SMITH DB (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: The Act limits how insurers, OHA and CCOs may conduct audits. The Act adds new information that some carriers must report to DCBS. (Flesch Readability Score: 62.7).

[*Digest: The Act limits how insurers, OHA and CCOs may conduct audits. The Act adds new information that some carriers must report to DCBS. The Act takes effect 91 days after session ends. (Flesch Readability Score: 66.4).*]

Imposes requirements and restrictions on insurer and coordinated care organization audits of claims for reimbursement submitted by behavioral health treatment providers. Becomes operative on January 1, 2027.

Adds information that certain carriers must annually report to the Department of Consumer and Business Services regarding compliance with behavioral health parity requirements.

[*Takes effect on the 91st day following adjournment sine die.*]

A BILL FOR AN ACT

Relating to behavioral health; creating new provisions; and amending ORS 743B.427.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2026 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Audit" means an on-site or remote review of records of or claims made by a provider by or on behalf of an insurer.

(b)(A) "Behavioral health treatment" includes:

(i) Mental health treatment and services as defined in ORS 743B.427; and

(ii) Substance use disorder treatment and services as defined in ORS 743B.427.

(B) "Behavioral health treatment" does not include treatment or services provided in:

(i) A hospital;

(ii) A hospital-affiliated clinic, as defined in ORS 442.612; or

(iii) A group medical practice that includes outpatient mental health or substance use disorder treatment.

(c) "Claim" means a request made by a provider to an insurer to reimburse the cost of behavioral health treatment provided to a beneficiary of a policy or certificate of health insurance offered by the insurer.

(d) "Clerical error" means a minor error in the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence.

(e) "Fraud" means an intentional misrepresentation made by an individual with the knowledge that the misrepresentation could result in an unauthorized benefit to the indi-

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

vidual or to another person.

(f) "Provider" means a person who is licensed, certified or otherwise authorized to provide behavioral health treatment in this state.

(2) An insurer that offers a policy or certificate of health insurance that reimburses the cost of behavioral health treatment shall make available to all providers who submit claims a separate document containing a detailed written description of all requirements for the successful resolution of a claim that may be audited by the insurer in the future and the requirements that applied in any previous period during which a claim of the provider was audited. The description must:

(a) Be written in plain language that is easy to understand and that does not rely on references to other sources such as statutes or contract provisions;

(b) Provide examples of documentation requirements for the submission of claims;

(c) Identify which requirements may result in recoupment for failure to comply;

(d) Explain which requirements apply to in-network providers and which apply to out-of-network providers; and

(e) If the requirements differentiate between types of providers, explain the requirements applicable to each type of provider.

(3) An insurer may not recoup from a provider a payment on a claim if the insurer has failed to comply with subsection (2) of this section.

(4) An insurer shall notify providers no later than 30 days before the effective date of any changes made by the insurer to the requirements described in subsection (2) of this section. An insurer may not demand recoupment of a payment made on a claim based on new requirements if the insurer has failed to comply with this subsection.

(5) An insurer's audit of a claim:

(a) May not be conducted on any paid claim submitted by a provider on a date more than 12 months earlier or, in the case of suspected fraud, may not be conducted more than six years after the date payment was made on the claim;

(b) For an audit initiated after payment is made on a claim, must be completed no later than 180 days from the date the audit is initiated on the claim, unless a provider fails to submit records in a timely fashion or initiates an appeal of the insurer's audit finding;

(c) Must be reviewed by a behavioral health professional; and

(d) May not result in reversing or overturning a determination that a service is medically necessary that was made by the insurer when the claim was submitted or prior authorization of the service approved, unless the patient was no longer insured at the time the service was provided.

(6) If an insurer uses sampling or similar methods to determine whether to initiate an audit of a provider's claims, the insurer:

(a) May initiate an audit only if the insurer identifies a high probability of an error; and

(b) May recoup from a provider only payments on individual claims for which the insurer specifically identifies an error.

(7) In the course of an audit initiated prior to payment on a claim, an insurer shall respond to a provider with findings no later than 30 days after the date the provider responds to the insurer's request for additional information regarding the claim.

(8) An insurer may not demand recoupment of a payment made on a claim based on a clerical error.

(9) If an insurer identifies an error during an audit of a claim that results in the insurer's demand for recoupment of the insurer's payment on the claim, the insurer:

(a) Shall provide a detailed description of the error and allow a provider a reasonable opportunity of not less than 30 days to rectify the error; and

(b) Shall allow the provider to use a repayment plan of up to three years to repay the claim unless the recoupment is based on an insurer's duplicate payment on a claim.

(10) An insurer may not begin a new audit of any claim submitted by a provider while another audit is in process. A subsequent audit may not be initiated until the provider has been given the opportunity to correct mistakes identified in the previous audit and complete any corrective action plan resulting from the previous audit.

(11) An insurer conducting an audit may not structure compensation paid to an employee or agent conducting an audit in any manner that creates a direct financial incentive to the employee or agent to identify errors that result in recoupment.

(12) An insurer may not charge a provider for the costs of conducting an audit.

(13) The provisions of this section apply to audits conducted by an insurer and to audits conducted by a third party on behalf of an insurer.

(14) In the event of an audit dispute between a provider and an insurer, the insurer:

(a) Shall continue to cover medically necessary services for the patient during the dispute, unless the insurer finds clear evidence of fraud or immediate patient safety concerns.

(b) May not hold the patient financially responsible for services deemed medically necessary at the time of delivery, even if the provider is later subject to recoupment.

SECTION 3. Section 4 of this 2026 Act is added to and made a part of ORS chapter 414.

SECTION 4. (1) As used in this section:

(a) "Audit" means an on-site or remote review of records of or claims made by a provider by or on behalf of a coordinated care organization or the Oregon Health Authority.

(b)(A) "Behavioral health treatment" includes:

(i) Mental health treatment and services as defined in ORS 743B.427; and

(ii) Substance use disorder treatment and services as defined in ORS 743B.427.

(B) "Behavioral health treatment" does not include treatment or services provided in:

(i) A hospital;

(ii) A hospital-affiliated clinic, as defined in ORS 442.612; or

(iii) A group medical practice that includes outpatient mental health or substance use disorder treatment.

(c) "Claim" means a request made by a provider to a coordinated care organization or the authority to reimburse the cost of behavioral health treatment provided to a member of the coordinated care organization or to a medical assistance recipient who is not enrolled in a coordinated care organization.

(d) "Clerical error" means a minor error in the keeping, recording or transcribing of records or documents or in the handling of electronic or hard copies of correspondence.

(e) "Fraud" means an intentional misrepresentation made by an individual with the knowledge that the misrepresentation could result in an unauthorized benefit to the individual or to another person.

(f) "Provider" means an individual who is licensed, certified or otherwise authorized to provide behavioral health treatment in this state.

(2) A coordinated care organization and the Oregon Health Authority shall make avail-

able to all providers all of the following regarding the requirements for the submission of claims:

(a) Examples of documentation requirements for the submission of claims;

(b) Identification of which requirements may result in recoupment for failure to comply;

(c) An explanation of which requirements apply to in-network providers and which apply to out-of-network providers; and

(d) If the requirements differentiate between types of providers, an explanation of the requirements applicable to each type of provider.

(3) A coordinated care organization and the authority shall notify providers no later than 30 days before the effective date of any contract changes by the coordinated care organization or changes by the authority to relevant administrative rules.

(4) An audit of a claim:

(a) May not be conducted on any paid claim submitted by a provider on a date more than three years earlier without an indication of fraud or an improper payment;

(b) Except as provided in subsection (5) of this section, must be completed no later than 180 days from the date an audit is initiated on a claim;

(c) Must be conducted by a behavioral health professional; and

(d) May not result in reversing or overturning a determination that a service is medically necessary made by a coordinated care organization or the authority when prior authorization of the service was given.

(5) In the course of an audit, if a coordinated care organization or the authority requests additional information regarding a claim, the coordinated care organization or the authority shall respond to a provider with findings no later than 180 days after the date the audit was initiated, unless an extension is agreed to in writing by all parties.

(6) If a coordinated care organization or the authority identifies an error during an audit of a claim that results in a demand for recoupment of the payment on the claim:

(a) The coordinated care organization or the authority shall work with the provider on a repayment plan, if requested.

(b) The provider may request, and is entitled to receive, a revised audit if the provider has reason to believe that the coordinated care organization or the authority based the finding of error on an incorrect provision of law.

(7) Unless required by federal law, a coordinated care organization or the authority conducting an audit may not compensate an individual for conducting the audit in an amount that is based on a percentage of the overpayments recouped or in any other way that creates a financial incentive to identify errors that result in recoupment.

(8) The provisions of this section apply to audits conducted by a coordinated care organization and the authority and to audits conducted by a third party on behalf of a coordinated care organization or the authority.

(9) In the event of an audit dispute between a provider and a coordinated care organization or the authority, the coordinated care organization or the authority:

(a) Shall continue to cover medically necessary services for the patient during the dispute, unless the coordinated care organization or the authority finds clear evidence of fraud or immediate patient safety concerns.

(b) May not hold the patient financially responsible for services deemed medically necessary at the time of delivery, even if the provider is later subject to recoupment.

SECTION 5. Sections 2 and 4 of this 2026 Act apply to audits initiated on or after January 1, 2027.

SECTION 6. (1) Sections 2 and 4 of this 2026 Act become operative on January 1, 2027.

(2) An insurer, a coordinated care organization and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the authority by sections 2 and 4 of this 2026 Act.

SECTION 7. ORS 743B.427 is amended to read:

743B.427. (1) As used in this section:

(a) "Behavioral health benefits" means insurance coverage of mental health treatment and services and substance use disorder treatment and services.

(b) "Carrier" has the meaning given that term in ORS 743B.005.

(c) "Fraud" has the meaning given that term in section 2 of this 2026 Act.

[*(c)*] **(d)** "Geographic region" means the geographic area of the state established by the Department of Consumer and Business Services for the purpose of determining geographic average rates, as defined in ORS 743B.005.

[*(d)*] **(e)** "Health benefit plan" has the meaning given that term in ORS 743B.005.

[*(e)*] **(f)** "Median maximum allowable reimbursement rate" means the median of all maximum allowable reimbursement rates, minus incentive payments, paid for each billing code for each provider type during a calendar year.

(g) "Medical management" includes policies or practices such as preauthorizations, audits, prepayment reviews, post-payment reviews, clinical reviews, utilization reviews, utilization monitoring or restriction of specific billing codes, reimbursement restriction of specific billing codes, denial of claims and recoupment of paid claims.

[*(f)*] **(h)** "Mental health treatment and services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

[*(g)*] **(i)** "Nonquantitative treatment limitation" means a limitation**, such as a medical management policy or practice,** that is not expressed numerically but otherwise limits the scope or duration of behavioral health benefits.

[*(h)*] **(j)** "Substance use disorder treatment and services" means the treatment of or services provided to address any condition or disorder that falls under any of the diagnostic categories listed in the substance use section of the current edition of the:

(A) International Classification of Disease; or

(B) Diagnostic and Statistical Manual of Mental Disorders.

(2) Each carrier that offers an individual or group health benefit plan in this state that provides behavioral health benefits shall conduct an annual analysis of whether the processes, strategies, specific evidentiary standards or other factors the carrier used to design, determine applicability of and apply each nonquantitative treatment limitation to behavioral health benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, specific evidentiary standards or other factors the carrier used to design, determine applicability of and apply each nonquantitative treatment limitation to medical and surgical benefits

within the corresponding classification of benefits.

(3) On or before March 1 of each year, all carriers that offer individual or group health benefit plans in this state that provide behavioral health benefits shall report to the Department of Consumer and Business Services, in the form and manner prescribed by the department, the following information:

(a) The specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(b) The factors used to determine that the nonquantitative treatment limitations will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(c) The evidentiary standards used for the factors identified in paragraph (b) of this subsection, when applicable, provided that every factor is defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health or substance use disorder benefits and medical or surgical benefits.

(d) The comparative analyses demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification.

(e) The specific findings and conclusions reached by the insurer with respect to the health insurance coverage, including any results of the analyses described in paragraphs (a) to (d) of this subsection that indicate that the plan or coverage is or is not in compliance with this section.

(f) The number of denials of behavioral health benefits and medical and surgical benefits, the percentage of denials that were appealed, the percentage of appeals that upheld the denial and the percentage of appeals that overturned the denial.

(g) The percentage of claims for behavioral health benefits and medical and surgical benefits that were paid to in-network providers and the percentage of such claims that were paid to out-of-network providers.

(h) The median maximum allowable reimbursement rate for each time-based office visit billing code for each behavioral treatment provider type and each medical provider type.

(i) The reimbursement rate in each geographic region for a time-based office visit and the percentage of the Medicare rate the reimbursement rate represents, paid to:

(A) Psychiatrists.

(B) Psychiatric mental health nurse practitioners.

(C) Psychologists.

(D) Licensed clinical social workers.

(E) Licensed professional counselors.

(F) Licensed marriage and family therapists.

(j) The reimbursement rate in each geographic region for a time-based office visit and the percentage of the Medicare rate the reimbursement rate represents, paid to:

(A) Physicians.

(B) Physician associates.

(C) Licensed nurse practitioners.

(k) For all behavioral health and medical and surgical claims, the criteria used to select any claim that includes office visit billing codes for medical management or investigation for

fraud.

(L) Medical management policies or practices that monitor or restrict provider utilization of particular behavioral health or medical and surgical office visit billing codes.

(m) The number and percentage of the total annual claims that include behavioral health or medical and surgical office visit billing codes subject to medical management, listed by each type of medical management policy or practice.

(n) Any deviation in the methodology used to determine the reimbursement for a behavioral health or medical and surgical office visit billing code that differs from the methodology used to reimburse other office visit billing codes.

[*(k)*] **(o)** The specific findings and conclusions of the carrier under subsection (2) of this section demonstrating compliance with ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343) and rules adopted thereunder.

[*(L)*] **(p)** Other data or information the department deems necessary to assess a carrier's compliance with mental health parity requirements.

(4) Each carrier that offers an individual or group health benefit plan in this state that provides behavioral health benefits and conducts medical management shall provide to the behavioral health provider in writing:

(a) The type and purpose of the medical management policy or practice;

(b) The criteria used to select the provider for review;

(c) Whether the provider may be subject to delays of future payments or recoupments of past payments; and

(d) An attestation that the medical management policy or practice utilized is being applied with the same frequency to a medical or surgical classification of benefits as described by ORS 743A.168 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

[*(4)*] **(5)** All documents provided to, disclosed to or obtained by the Department of Consumer and Business Services pursuant to subsection (3) of this section are provided, disclosed or obtained for the purpose of administering the Insurance Code and shall be confidential and not subject to public disclosure, as provided in ORS 705.137.

[*(5)*] **(6)** No later than September 15 of each calendar year, the department shall report to the interim committees of the Legislative Assembly related to mental or behavioral health, in the manner provided in ORS 192.245, a summary of the information reported under subsection (3) of this section, including the department's overall comparison of carriers' coverage of mental health treatment and services and substance use disorder treatment and services to carriers' coverage of medical or surgical treatments or services.
