2026 Behavioral Health Protection Bill (HB 4028)

(*Rep Harbick, Rep Nosse*)

HB 4028 combines provisions of the HB 2029 (2025) audit reforms with HB 3725 (2025) strategies to strengthen behavioral health parity.

Sections 1-6 (*General audit reform provisions from HB 2029*)

The *2026 Behavioral Health Protection Bill* – HB 4028 – incorporates the audit protection language from HB 2029 (2025) that has already been reviewed and unanimously approved by the House Behavioral Health and Health Care Committee in 2025.

The highlights of these provisions include:

- Requires insurers that reimburse behavioral health providers to make available a written description of all requirements for the successful resolution of a claim. Specifies form and contents of written description.
- Prohibits insurer from recouping payment on a claim if insurer has failed to comply with written description requirement.
- Reducing the insurer "clawback" window from the currently allowed 36 months to 12 months.
- Creating a timeframe of 180 days for insurers and CCOs to complete an audit of paid claims.
- Creating a timeframe of 30 days for insurers to complete pre-payment audits.
- Prohibits insurers from demanding recoupment of a payment made based on a "clerical error;" providing an opportunity of not less than 30 days for providers to correct identified errors.
- Allows providers who owe insurers to pay on a repayment plan over three years, replacing current Oregon law which allows insurers to claw back payments after 30 days.
- Prohibits insurers from conducting simultaneous audits of a provider.
- Prohibits insurers from structuring payment paid to employee or agent in a manner that creates a financial incentive for the employee or agent.
- Prohibits insurer from charging provider for audit costs.

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Section 7 *(General parity reporting requirements from HB 3725)*

HB 4028, Section 7 does the following:

- Increases transparency from insurers by requiring them to identify the medical management practice being applied, its purpose, and whether it may trigger an audit or "clawback."

- Expands the definition of "medical management" to give state regulators clearer visibility into the policies and practices behavioral health providers confront in the field that effectively reduce access to mental health care.

- Adds Behavioral Health Parity reporting requirements to highlight emerging tactics portrayed as medical management, such as *Coding Advisor Programs*, that target behavioral health providers for billing common services by giving the providers the impression of "potentially erroneous billing."

Increased Transparency

The improved reporting definitions in HB 4028 give DCBS a clearer view of the medical management NQTLs insurers apply to behavioral health providers. **The definitions specifically capture the policies and practices that are likely to create *operational differences* in access to care (eg. violate mental health parity requirements):**

- Section 7(g) defines "Medical management" to include policies or practices that include pre-authorizations, audits, prepayment reviews, post-payment reviews, clinical reviews, utilization reviews, utilization monitoring of specific billing codes, utilization restriction of particular billing codes, reimbursement restriction of particular billing codes, denial of claims and recoupment of paid claims.

- Section 7(i) adds to the definition of "Nonquantitative treatment limitation" to include a medical management policy or practice if the medical management policy or practice limits the scope or duration of treatment.

The 2026 Behavioral Health Protection Bill also includes protections that require transparent communication from insurers to behavioral health providers when conducting activities that fall under "medical management" as follows:

> Section 7 (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 technique utilized is being applied with the same frequency to a medical or surgical classification of benefits as described by ORS 743A.168 and the Mental Health Parity and Addiction Equity Act of 2008.

Improved Parity Reporting Requirements

Existing behavioral health parity reporting requirements established under HB 3046 (2021), and renewed by SB 824 (2025) have driven tangible gains in key indicators such as in-network utilization trends, denial rates, and reimbursement policies — without requiring enforcement actions. The transparency created by parity reporting has been enough to produce meaningful change.

However, as DCBS notes, there is a "lack of transparency" that acts as a barrier to "a comprehensive understanding of how NQTLs are applied and makes it difficult to assess whether they are being implemented in a manner that meets parity requirements." Insurance companies provide their own NQTL data and self-identify what is examined to make parity determinations.

All insurers stated in their reports that NQTLs are applied equally to behavioral health and medical-surgical benefits. However, most failed to furnish comprehensive evidence to support these claims. Insurers report NQTL data with wide variations from detailed narratives with supporting data to vague generalizations without evidence. —**2023 DCBS Report on Behavioral Health Parity (p. 13**)

Therefore, parity reporting requirements remain the most effective available tool to promote true mental health parity. The following additional reporting requirements in Section 7(3) of HB 4028 aim to improve data collection and reporting on specific medical management NQTLs confronting behavioral health providers in Oregon.

1. Insurers will identify and report in detail **all criteria used to select** any claim that includes behavioral health office visit billing codes for "medical management" or investigation for "fraud," as defined above.

2. Insurers will identify and report in detail all "medical management" policies and practices that **monitor and/or restrict provider utilization** of particular behavioral health office visit billing codes.

3. Insurers will report the **number and percentage of the total annual number of claims** that include behavioral health office visit billing codes subject to any "medical management," listed by each type of "medical management" policy or practice, as defined above.

4. Insurers will report any **deviation in the methodology used to determine the reimbursement** for any particular behavioral health office visit billing code, which is different than how they reimburse other behavioral health and medical office codes.