DEPARTMENT OF CONSUMER & BUSINESS SERVICES

NEWS RELEASE

Director's Office, 350 Winter St. NE, Room 200, Salem, Oregon 97301-3878

For immediate release:
March 2, 2017

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State to fine 4 insurers for violations involving mental health coverage

Salem – The Oregon Department of Consumer and Business Services (DCBS) has issued proposed enforcement orders to four health insurance companies for violating laws related to coverage of mental health treatments.

Oregon's mental health parity law requires insurers to cover mental health conditions consistent with how they cover physical conditions. The department issued guidance to insurers in 2014 that they cannot categorically deny coverage of mental health treatments, including Applied Behavior Analysis (ABA) therapy, which is used to treat autism.

"Despite our clear guidance to insurance companies on mental health parity, some companies continue to engage in practices that make it difficult for consumers to access treatment," said Laura Cali Robison, Oregon insurance commissioner and administrator of the DCBS Division of Financial Regulation. "We continue to monitor this issue across the industry and will not hesitate to take strong action if warranted."

The companies that are subject of the proposed orders are:

- Pioneer Educators Health Trust, which provides health plans to local universities, is fined a proposed $100,000 for several violations, including:
    - Applying an annual visitation limit for neurodevelopmental therapy, a mental health treatment, when there was not a similar limit for other medical or surgical benefits.
    - Excluding ABA therapy in its 2015 health benefit plan and issuing the plan without receiving approval from the state.
    - Denying a consumer's pre-authorization request for ABA therapy and not providing a written response with information about the consumer's right to appeal.
    - Denying a claim for ABA therapy with no basis for that denial.
- Regence BlueCross BlueShield of Oregon, in its role as third-party administrator for Pioneer Educators Health Trust, is fined a proposed $100,000. In particular, Regence provided incorrect information to Pioneer and at least one consumer about whether it was required to cover ABA therapy.
- United Healthcare Insurance Company is fined a proposed $110,000 for denying 22 speech therapy claims for children who have been diagnosed with a pervasive

developmental disorder (such as autism). Oregon law requires insurers to cover all medical services for a child enrolled in the plan who is younger than 18 years old and who has been diagnosed with a pervasive developmental disorder. Those services include rehabilitation services, such as speech therapy, that are medically necessary and are otherwise covered under the plan.

- Kaiser Foundation Health Plan of the Northwest is fined a proposed $250,000 for providing incorrect and misleading information in its member documents about whether it would pay for members' attorney fees in a lawsuit. Kaiser's documents stated that members would bear their own attorney fees, but Oregon law requires insurers to honor a court award for attorney fees. This order was the result of a complaint from a consumer who has filed a lawsuit against Kaiser related to mental health parity issues.

The division continues to work with the four companies to agree on final consent orders. Terms of the orders may change before a final order is issued.

The Division of Financial Regulation was formed last year after the merger of the Insurance Division of the Division of Finance and Corporate Securities.

"Since the creation of the new division, we have been able to develop a stronger enforcement presence and now have an increased ability to take swift action to protect Oregonians," said Patrick Allen, director of DCBS.

Consumers who have issues or questions about coverage of mental health treatments claims should contact the DCBS Division of Financial Regulation at 1-888-877-4894 (toll-free) or email cp.ins@state.or.us.

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STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of:	**Case No. INS-17-_____**
Kaiser Foundation Health Plan of the Northwest ("KFHPNW"),	**FINAL ORDER TO CEASE AND DESIST AND ORDER ASSESSING CIVIL PENALTIES, ENTERED BY CONSENT**
Respondent.	**THIS IS A FINAL ORDER**

The Director of the Department of Consumer and Business Services ("DCBS") for the State of Oregon ("the Director") has determined that Kaiser Foundation Health Plan of the Northwest ("Respondent" or "KFHPNW"), did not comply with ORS 746.110 and ORS 731.260, with respect to certain KFHPNW filings submitted to the Director.

KFHPNW submits to the Director's jurisdiction and agrees to waive their rights to notice and an administrative hearing that arise under ORS 183.415, and will resolve this matter by consenting to entry of this Final Order.

Now therefore, as evidenced by the signatures subscribed in this Order, Respondent hereby consents to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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I. FINDINGS OF FACT

The Director FINDS that at all times relevant to this Final Order:

1. KFHPNW is an Oregon domiciled health care service contractor that has been registered with DCBS since January 1981. Its National Association of Insurance Commissioner Number is 95540. The company's business address is 500 NE Multnomah Street Suite 100, Portland, Oregon, 97232-2099.

2. KFHPNW has approximately 293,000 members in plans that are regulated

by DCBS.

3. Since at least 2009 and continuing to on or about October 2016, KFHPNW provided health benefit plans to Oregon consumers through commercial plans. As part of the process of issuing plans to its members, KFHPNW is statutorily required to submit forms to the Director for approval, including Evidence of Coverage ("EOCs") forms and Member Agreements. During this seven year period, KFHPNW's EOCs and Member Agreements contained an Attorney Fee and Expense provision that stated, in relevant part:

> [*As applicable to EOCs*]:
>
> In any dispute between a Member and Company or Medical Group [Dental Group] or Kaiser Foundation Hospitals [Participating Providers or Participating Dental Offices] each party will bear its own attorneys' fees and expenses.
>
> [*As applicable to Member Agreements*]:
>
> Except as provided under the "Dispute Resolution" section of this Agreement, in any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses in any dispute.[1]

4. Upon information and belief, KFHPNW submitted multiple EOCs and Member Agreements to DCBS each year from 2009 to on or before October 2016.

5. Accompanying each EOC and Member Agreement that KFHPNW filed with the Director, the company also submitted a Certificate of Compliance ("COC"). The COC stated that the "filing submitted complies with the applicable Oregon laws, Oregon Administrative Rules, Oregon Insurance Bulletins […]." KFHPNW further

[1] For examples of EOCs containing the provision, *see*: Individuals and Families Deductible Plan Evidence of Coverage (effective January 1, 2016 to December 31, 2016) (amended October 17, 2016); Large Group Deductible Plan Evidence of Coverage (approved June 17, 2011); Small Group Pediatric Dental Choice Preferred Provider Organization Plan Evidence of Coverage (approved May, 8, 2013); Small Group Deductible Dental Plan Evidence of Coverage (approved July 19, 2012). For an example of a Member Agreement containing the provision, *see* Kaiser Permanente Individuals and Families Traditional Plan Member Agreement (effective October 1, 2009 to December 21, 2010).

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acknowledged that DCBS will, "rely on this certificate" and could take "corrective… action including monetary penalties" against KFHPNW if the filing is "false or misleading."

6. After the Director approves KFHPNW's EOCs and Member Agreements, KFHPNW makes these documents available to members by web-posting, mail or otherwise.

7. On or about September 2016, DCBS received a complaint from a Kaiser member, Paul Terdal, who alleged that KFHPNW's Attorney Fee and Expense not only conflicted with ORS 742.061, but that the contractual provision adversely affected his ability to retain legal services in an action he filed against KFHPNW. Accordingly, Mr. Terdal filed a legal action against KFHPNW on a *pro se* basis (e.g., on his own). *See Paul Terdal v. KFHPNW*, Case Number 15-CV-30756 (State of Oregon Circuit Court for Multnomah County). The court dismissed Mr. Terdal's action, in part, because Mr. Terdal failed to state a claim for relief.

8. After receiving Mr. Terdal's information, DCBS informed KFHPNW that its Attorney Fee and Expense provision should be amended in light of ORS 742.061.

9. ORS 742.061 provides in relevant part:

> Except as otherwise provided in subsections (2) and (3) of this section, if settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought in any court of this state upon any policy of insurance of any kind or nature, and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the costs of the action and any appeal thereon.

10. On October 17, 2016, KFHPNW attested that EOCs containing the Attorney Fee and Expense provision will "continue to substantively comply with ORS 742.061 … [for] 2017 contracts." KFHPNW amended its EOCs on a going forward basis by expressly stating that a member will bear its own attorneys' fees and expenses,

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"*except as otherwise required by law*." The italicized provision means, in effect, KFHPNW will honor a court award for attorney fees owed to a member.

11. Despite knowing that KFHPNW's Attorney Fee and Expense provision conflicted with ORS 742.061, on December 21, 2016, KFHPNW argued that Mr. Terdal's claim for attorney fees should be dismissed, in part, because "the contract between Kaiser and the Terdals clarifies that each party will bear their own attorney fees and expenses." *See* KFHPNW's Rule 21 Motion 13:23-24, *Paul Terdal v. KFHPNW*, Case Number 15-CV-30756 (State of Oregon Circuit Court for Multnomah County).

II. CONCLUSIONS OF LAW

The Director CONCLUDES that:

1. Paragraphs 1-11 are incorporated.

2. The Director has general jurisdiction over KFHPNW and the subject matter described above. *See* ORS 731.236, ORS 731.402(1) (certificate of authority).

3. The Director has enforcement authority over KFHPNW. ORS 731.256.

4. KFHPNW is a "health service contractor." ORS 750.005(4)(a).

5. KFHPNW must file forms with the Director under ORS 742.003, pursuant to ORS 750.055(1)(g).

6. KFHPNW is statutorily obligated to make its policy forms available to its members. ORS 742.046.

7. KFHPNW is subject to ORS 742.061, pursuant to ORS 750.055(1)(g).

8. Under ORS 746.110, "[n]o person shall … place before the public … in any [ ] way … [a] statement with respect to the business of insurance … which is untrue, deceptive or misleading." KFHPNW's EOCs and Member Agreements contained an Attorney Fee and Expense provision that was untrue regarding the recovery of attorney fees in a dispute, in violation of ORS 746.110.

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9. Under ORS 731.260, "[n]o person shall file … with the Director … any … certificate … required or permitted to be so filed under the Insurance Code and known to such person to be false or misleading in any material respect." From 2009 to on or about October 2016, KFHPNW violated ORS 731.260 by filing COCs with the Director that purported to comply with Oregon law, when in fact, KFHPNW's Attorney Fee and Expense provision violated ORS 742.061.

10. Pursuant to ORS 731.988(1), the Director may impose a civil penalty of up to $10,000 per violation upon any person who violates any provision of the Insurance Code, ORS 731.004*, et seq*.

III. ORDERS

Now therefore, the Director issues the following Orders:

1. As authorized by ORS 731.252(1), the Director ORDERS KFHPNW to CEASE AND DESIST from violating any provision of the Insurance Code or the administrative rules promulgated thereunder.

2. In accordance with ORS 731.988(1), the Director assesses a CIVIL PENALTY of Two Hundred Fifty Thousand Dollars ($250,000) for multiple violations of ORS 746.110 and ORS 731.260. One Hundred Fifty Thousand Dollars is due and payable to DCBS at the time this Final Order becomes effective.

The remaining balance of One Hundred Thousand Dollars $100,000 is SUSPENDED and will not be collected on only if KFHPNW submits no filings that the Director finds violate ORS 746.110 or ORS 731.260.

3. This is a "Final Order" under ORS 183.310(6)(b). Subject to that provision, entry of this Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Director under Oregon law to enforce this Order, for violations of this Order, for conduct or actions of KFHPNW that are not covered by this Order, or against any party not covered by this Order.

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SO ORDERED this ____day of _____, 2017.

PATRICK M. ALLEN, Director
Department of Consumer and Business Services

_____
David C. Tatman, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, _____, state that I am an officer of Kaiser Foundation Health Plan of the Northwest ("KFHPNW"), and that I am authorized to act on its behalf; that I have read the foregoing Order and that I know and fully understand the contents hereof; that I have been advised of KFHPNW's right to a hearing in this matter; that KFHPNW has been represented by counsel in this matter; that KFHPNW voluntarily and without any force or duress, consents to the entry of this Order, expressly waiving any right to a hearing in this matter; that KFHPNW executes this Order as a settlement of the matters referred to in the foregoing Order; that KFHPNW understands that the Director reserves the right to take further actions to enforce this Order or to take appropriate action upon discovery of other violations of the Insurance Code by KFHPNW, and; that KFHPNW will fully comply with the terms and conditions stated herein.

KFHPNW understands that this Order is a public document.

By: _____
Signature
By: _____
Printed Name

Office Held: _____

State of OREGON
County of _____

There appeared before me this ___day of _____, 2017, _____, and stated that he/she was and is an officer of Respondent, and that he/she is authorized and empowered to sign this Order on behalf of Respondent, and to bind it to the terms hereof.

_____
Notary Public - State of Oregon

Approved as to form:

_____ _____
Date

Attorney for KFHPNW

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STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of: PIONEER EDUCATORS HEALTH TRUST, Respondent.	Case No. INS-17-0016 FINAL ORDER TO CEASE AND DESIST AND ORDER ASSESSING CIVIL PENALTIES, ENTERED BY CONSENT

WHEREAS, the Director of the Department of Consumer and Business Services for the State of Oregon ("***Director***"), acting in accordance with Oregon Revised Statutes ("***ORS***") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("***Insurance Code***"), has conducted an investigation of Pioneer Educators Health Trust ("***Respondent***") regarding violations of the Insurance Code; and

WHEREAS Respondent wishes to resolve this matter with the Director;

NOW THEREFORE, as evidenced by the signatures subscribed in this Order, Respondent hereby CONSENTS to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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FINDINGS OF FACT

The Director FINDS that:

1. The Director, by and through the Division of Financial Regulation, previously known as the Insurance Division (collectively the "***Division***"), granted Respondent a Certificate of Authority to operate as an Oregon multiple employer welfare arrangement ("***MEWA***") on or around April 14, 2003. A MEWA is an arrangement where a group of employers pool their contributions in a self-contributing benefits plan for their

employees. Respondent's National Association of Insurance Commissioners ("***NAIC***") company number is 12619.

2. Respondent is a self-funded large group MEWA that, at relevant times, provided a health benefit plan to higher educational institutions located in Oregon, including the following: Lewis & Clark College; Corban University; George Fox University; Linfield College; Pacific University; Reed College; the University of Western States; and Willamette University (collectively the "***Member Institutions***"). Respondent provided benefits for approximately 1,700 employees of the Member Institutions.

3. Respondent's Plan year runs from April 1st to March 31st of each year. Thus, Respondent's 2015 health benefit plan governed coverage for the period April 1, 2015 through March 31, 2016.

4. Regence BlueCross BlueShield of Oregon ("***Regence***"), NAIC company number 54933, is the third party administrator for Respondent, pursuant to a certain Administrative Services Contract between Regence and Respondent, dated April 1, 2015 (the "***TPA Contract***"). During the 2015 plan year, Respondent delegated certain administrative duties to Regence including, among other services, claims processing services and drafting and making recommendations for the 2015 health benefit plan documents. Under the TPA Contract, notwithstanding any services provided by Regence, Respondent is the plan administrator, the named fiduciary, and has the ultimate responsibility for sponsoring, amending, designing and terminating the health benefit plan, and complying with all applicable law as related to the plan.

5. On November 14, 2014, the Division issued Oregon Insurance Division Bulletin INS 2014-2 (the "***Bulletin***"), explaining the requirements relating to health benefit plan coverage for autism spectrum disorder ("***ASD***") and other pervasive developmental disorders ("***PDDs***") , including the treatment known as applied behavioral analysis ("***ABA***"). The Bulletin provided, in part:

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> An insurer may not apply a categorical exclusion (such as exclusions for developmental, social or educational therapies) that results in a denial of all ABA or other medically necessary treatment or otherwise results in the mandates[1] being effectively meaningless for ASD or PDDs.
>
> The Oregon PDD statute [ORS 743A.190] requires a health benefit plan to cover, for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder, all medical services that are medically necessary and are otherwise covered under the plan. The statute includes, as medical services, rehabilitation services defined to include physical therapy, occupational therapy or speech therapy services. Therefore, the mandate for medical services requires at least some of both behavioral and physical services. ABA is a behavioral service and is included among "all medical services."
>
> An insurer's denial of coverage on a basis prohibited by this bulletin may subject the insurer to enforcement measures for violation of the Oregon Insurance Code.

6. On or around October 1, 2014, prior to issuance of the Bulletin, Regence delivered a recommended health benefit plan to Respondent for approval for the 2015 plan year. The plan specifically excluded coverage for ABA therapy.

7. Following issuance of the Bulletin, on or around January 6, 2015, Regence advised Respondent that the ASD and ABA mandates set forth in the Bulletin did not apply to Respondent, given its status as a MEWA. Accordingly, on or around February 5, 2015, Respondent approved the plan recommended by Regence.

8. Respondent's 2015 Medical and Vision Plan (the "***2015 Plan***"), effective on April 1, 2015, included the following office visit limitation and general categorical exclusion applicable to ASD, PDD and ABA:

> **NEURODEVELOPMENTAL THERAPY**
> **Outpatient limit**: 25 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services.
> The Plan covers physical therapy, occupational therapy or speech therapy

[1] Referring to the following state and federal mental health mandates: Oregon Revised Statute ("***ORS***") 743A.190 – Oregon Mandatory Coverage for Minors with Pervasive Development Disorders ("***Oregon PDD***"); Enrolled Senate Bill 365 (2013 Legislative Session, 2013 Oregon Laws Chapter 771 ("***SB 365***"); ORS 743A.168 – Oregon Mental Health Parity ("***Oregon MHP***"); 29 U.S.C. Sec. 1185a – federal Mental Health Parity and Addition Equity Act ("***MHPAEA***").

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services to restore or improve function, for a pervasive developmental disorder, for a Claimant age 17 and under. For the purpose of this benefit, "pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability, or mental retardation.

GENERAL EXCLUSIONS: The following are the general exclusions from coverage under the Plan.
Applied Behavioral Analysis treatment by any Provider for any condition

9. With respect to the annual 25 visit limitation for neurodevelopmental therapy, the 2015 Plan did not impose the same or a similar annual visit limitation for substantially all (at least two –thirds) of the medical or surgical benefits covered under the 2015 Plan.

10. Respondent did not submit the 2015 Plan to the Division for approval prior to its distribution to Member Institutions and use by Regence for claims processing.

11. The unapproved 2015 Plan was used by Regence to process claims between April 1, 2015 and on or around September 30, 2015.

12. Respondent delivered the unapproved 2015 Plan to the Member Institutions for distribution to enrollees in the plan. The 2015 Plan was available to enrollees and the general public on the websites of at least three of the Member Institutions until approximately December 2016.

I. Denial of Preauthorization Requests for ABA Therapy

13. The Oregon consumer identified herein as "***HS***" was an enrollee in the 2015 Plan.

14. In or around July 2015, HS made a number of verbal preauthorization requests to Regence, seeking prior authorization for coverage of ABA therapy for her minor dependent that had been diagnosed with ASD and prescribed ABA therapy as medically necessary treatment. In response to each such request, Regence verbally represented to HS that ABA therapy was not a covered benefit. Regence failed to provide a denial of the

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preauthorization requests in writing, as requested by HS. Regence further represented to HS that Respondent was exempt from the mandates for ABA therapy explained in the Bulletin.

15. On July 23, 2015, HS submitted a written preauthorization request to Regence, via facsimile, seeking prior authorization for coverage of ABA therapy.

16. The 2015 Plan provides that responses to preauthorization requests will be provided, in writing, within 15 calendar days from receipt of the preauthorization request.

17. HS did not receive a written response to her July 23, 2015 preauthorization request within the 15 day timeframe provided for in the 2015 Plan, or by August 7, 2015. Accordingly, on August 18, 2015, HS mailed Regence the same preauthorization request submitted on July 23rd, and again requested a written response to the same.

18. On or around August 19, 2015, Regence responded to HS's preauthorization request with a denial letter. The denial letter did not include any information relating to the grievance and appeal process, the process for seeking assistance from the Division concerning the denial, or the contact information for the Division.

19. Notwithstanding, HS sought an appeal of her preauthorization request denial from Regence.

20. On September 4, 2015 Regence issued a letter denying HS's request for an appeal, stating "we are unable to accept this appeal since preauthorization is not required for services that are not covered…According to page 29 of the Pioneer Educators Health Trust Summary Plan Description, ABA treatment by any provider for any condition is listed as a specific exclusion."

21. On or around August 2, 2015, HS filed a complaint with the Division regarding the verbal preauthorization denials she received from Respondent, through Regence, and the general exclusion for ABA therapy coverage contained in the 2015 Plan.

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22. The Division contacted Respondent regarding the complaint filed by HS, and advised Respondent that the 2015 Plan was not in compliance with state and federal mental health parity laws.

23. Following correspondence with the Division, on or around September 30, 2015, Respondent directed Regence to include ABA therapy as a covered service under the 2015 Plan, retroactive to April 1, 2015. On or around October 13, 2015, Respondent internally approved an amended 2015 Plan, removing the ABA therapy exclusion (the "***Amended 2015 Plan***"). Regence began using the Amended 2015 Plan to process preauthorization requests and claims for ABA therapy beginning in October 2015.

24. Respondent, through Regence, granted HS's preauthorization request for ABA therapy on or around November 18, 2015, almost four months after HS made the initial request for preauthorization of ABA therapy for her minor dependent.

25. On or around November 4, 2015, Respondent provided the Amended 2015 Plan to the Member Institutions, explaining that the amended plan removed "the Exclusion of Applied Behavioral Analysis treatment as required by state law effective 4/1/15." Respondent requested that the Member Institutions replace all posted or printed plan documents for the 2015 Plan with the Amended 2015 Plan. At least three of the Member Institutions failed to remove the 2015 Plan containing the ABA exclusion from their websites until December 2016. However, all claims and preauthorization requests for ABA therapy received on or after October 1, 2015 were processed according to the Amended 2015 Plan.

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II. Denial of ABA Therapy Claim

26. The Oregon consumer identified herein as "***MM***" was an enrollee in Respondent's health benefit plan that was effective from April 1, 2014 through March 31, 2015 (the "***2014 Plan***"). The 2014 Plan did not include the same ABA exclusion or annual 25 visit limitation for neurodevelopmental therapy treatments of ASD that were

improperly included in the 2015 Plan.

27. In October 2015, MM submitted a claim to Regence for coverage of ABA therapy for her minor dependent. The claim was for services received by MM's dependent on or around March 18, 2015, after issuance of the Bulletin clarifying the ABA therapy coverage mandates.

28. Regence denied the claim, despite the lack of a specific exclusion for ABA therapy in the 2014, and despite the mandates for ABA therapy discussed in the Bulletin.

29. On September 21, 2015, following the Division's discovery of the mental health parity compliance issues identified in the 2015 Plan, Respondent represented to the Division that it would identify other consumers that may have been similarly impacted and take appropriate action to remedy the harm. Despite this representation, MM's claim for ABA therapy was improperly denied and was never reprocessed or re-adjudicated.

30. Regence did approve subsequent claims for coverage of ABA therapy submitted by MM.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

31. Respondent is a "carrier" that offered a "health benefit plan" to Oregon consumers, as those terms are defined by ORS 743B.005, and is subject to regulation by the Director.

32. Under ORS 750.333(1), Respondent is subject to the requirements of ORS 743A.168, 742.003, 743B.250, 746.230 and 731.988.

33. Under ORS 744.740, and notwithstanding Respondent's use of Regence as its third party administrator, Respondent is responsible for determining the benefits and claims payment procedures applicable to the health plan provided to its Member Institutions, and is solely responsible for providing competent administration of its programs.

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34. Under ORS 743A.168, a group health insurance policy must provide coverage for treatment of mental health conditions at the same level as, and subject to limitations no more restrictive than, treatments for other medical or surgical conditions.

35. Under Oregon Administrative Rule ("***OAR***") 836-053-1405(2)(c), if an insurer applies annual limits to treatment of mental health conditions, the limits must comply with the "predominantly equal" to and "substantially all" tests set forth in the MHPAEA and implementing regulations at 45 CFR 146.136 and 147.160.

36. Under MHPAEA, an annual visit limitation for the treatment of mental health conditions is prohibited unless an insurer can establish that the limitation is not more restrictive than the limitation that the insurer applies to substantially all (at least two – thirds) of medical or surgical benefits in the same classification. 29 U.S.C. Sec. 1185(a); 29 CFR 2590.712.

37. The annual office visit limitation for Neurodevelopmental Therapy (physical, occupational, and speech therapy) in Respondent's 2015 Plan, as more fully discussed in Paragraph 8 above, violated ORS 743A.168 and OAR 836-053-1405(2)(c).

38. The general exclusion of coverage for ABA therapy in Respondent's 2015 Plan, as more fully discussed in Paragraph 8 above, violated ORS 743A.168.

39. Under ORS 742.003(1), a health benefit plan policy form must be filed with and approved by the Director before it is delivered or issued for delivery in Oregon.

40. Respondent violated ORS 742.003(1) when it issued the 2015 Plan and delivered it to the Member Institutions for distribution to the approximate 1,700 enrollees in the plan before it was filed, let alone approved, by the Director.

41. Respondent violated ORS 743A.168 when it denied HS's preauthorization request for ABA therapy.

42. Under ORS 743B.001(c), an "adverse benefit determination" includes an insurer's denial of a health care service that is based on a network exclusion, annual

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benefit limit, or other limitation on otherwise covered services.

43. Respondent's denial of HS's request for preauthorization of ABA therapy was an adverse benefit determination.

44. Under ORS 743B.250(2) and (4) (renumbered from ORS 743.804) an insurer must establish procedures for grievances, appeals and external reviews, and must provide notice of such procedures to an enrollee that is notified of an adverse benefit determination and files a grievance or appeal.

45. Under OAR 836-053-1110, a written decision by an insurer in response to a grievance must prominently disclose the following information: (1) that the enrollee has a right to file a complaint or seek other assistance from the Division; and (2) the contact information for the Division.

46. Respondent violated ORS 743B.250(2) when it failed to establish procedures relating to denials of ABA therapy that allowed HS to file a grievance or appeal, or seek an external review of the adverse benefit determination denying coverage for ABA therapy.

47. Respondent violated ORS 743B.250(4) and OAR 836-053-1110 when it issued an adverse benefit determination to HS and failed to include the required information concerning grievances, appeals, external review, and assistance from the Division.

48. Respondent violated ORS 743A.168 when it denied MM"s claim for ABA therapy.

49. Under ORS 746.230(1), no insurer or other person shall commit or perform any of the following unfair claim settlement practices, among others: (d) refusing to pay claims without conducting a reasonable investigation based on all available information; (f) not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear.

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50. Respondent violated ORS 746.230(1) (d) and (f) when it denied MM's claim for ABA therapy despite the lack of any basis for the denial in the 2014 Plan, and despite the clear guidance set forth in the Bulletin regarding ABA therapy mandates.

51. Under ORS 731.988(1), the Director may assess a civil penalty of up to $10,000 against any person that violates a provision of the Insurance Code or any lawful rule or final order of the Director. Each violation is a separate offense.

ORDERS

Now therefore, the Director issues the following Orders:

52. As authorized by ORS 731.252(1), the Director ORDERS Respondent to CEASE AND DESIST from violating any provision of the Insurance Code or the administrative rules promulgated thereunder.

53. As authorized by ORS 731.988(1), the Director hereby assesses CIVIL PENALTIES against Respondent in the total amount of One Hundred Thousand Dollars ($100,000), as follows:

A. A CIVIL PENALTY of Twenty Thousand Dollars ($20,000) for violations of ORS 743A.168 and OAR 836-053-1405(2)(c) with respect to the annual office visit limitation for Neurodevelopmental Therapy in Respondent's 2015 Plan;

B. A CIVIL PENALTY of Twenty Thousand Dollars ($20,000) for violations of ORS 743A.168 with respect to the general exclusion of coverage for ABA therapy in Respondent's 2015 Plan;

C. A CIVIL PENALTY of Twenty Thousand Dollars ($20,000) for violations of ORS 742.003(1), resulting from Respondent's issuance and distribution of the 2015 Plan without having filed and received approval for the form from the Director;

D. A CIVIL PENALTY of Twenty Thousand Dollars ($20,000) for violations of ORS 743A.168, 743B.250(2), 743B.250(4) and OAR 836-053-1110 with respect to Respondent's denial of HS's preauthorization request for ABA therapy;

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E. A CIVIL PENALTY of Twenty Thousand Dollars ($20,000) for violations of ORS 743A.168 and ORS 746.230(1)(d) and (f) with respect to Respondent's denial of MM's claim for ABA therapy.

54. The Director SUSPENDS the collection of $50,000 of the total CIVIL PENALTY assessed above, so long as Respondent complies with all terms and conditions of this Consent Order and all requirements of the Oregon Insurance Code. If Respondent complies with the terms of this Consent Order and the Director has not initiated an enforcement action for new violations of the Oregon Insurance Code during the three-year period from the effective date of this Consent Order, the Director WAIVES the collection of the suspended CIVIL PENALTY assessed herein.

55. The $50,000 CIVIL PENALTY assessed above that is not suspended is due and payable at the time this Consent Order is returned to the Division.

56. This Order is a "Final Order" under ORS 183.310(6)(b). Subject to that provision, entry of this Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Director under Oregon law to enforce this Order, for violations of this Order, for conduct or actions of Respondent that are not covered by this Order, or against any party not covered by this Order.

SO ORDERED this ____ day of _____, 2017.

PATRICK M. ALLEN, Director
Department of Consumer and Business Services

_____
David C. Tatman, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, _____, state that I am an officer of Pioneer Educators Health Trust ("***Respondent***"), and that I am authorized to act on its behalf; that I have read the foregoing Order and that I know and fully understand the contents hereof; that I have been advised of Respondent's right to a hearing in this matter; that Respondent has been represented by counsel in this matter; that Respondent voluntarily and without any force or duress, consents to the entry of this Order, expressly waiving any right to a hearing in this matter; that Respondent executes this Order as a settlement of the matters referred to in the foregoing Order; that Respondent understands that the Director reserves the right to take further actions to enforce this Order or to take appropriate action upon discovery of other violations of the Insurance Code by Respondent, and; that Respondent will fully comply with the terms and conditions stated herein.

Respondent understands that this Order is a public document.

By: _____
Signature

By: _____
Printed Name

Office Held: _____

State of OREGON
County of _____

There appeared before me this ___day of _____, 2017, _____, and stated that he/she was and is an officer of Respondent, and that he/she is authorized and empowered to sign this Order on behalf of Respondent, and to bind it to the terms hereof.

_____
Notary Public - State of Oregon

Approved as to form:

_____ _____
Jeffrey G. Robertson, OSB No. 031673 Date
Attorney for Respondent

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STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of: REGENCE BLUECROSS BLUESHIELD OF OREGON, Respondent.	Case No. INS-17-0017 FINAL ORDER TO CEASE AND DESIST AND ORDER ASSESSING CIVIL PENALTIES, ENTERED BY CONSENT

WHEREAS, the Director of the Department of Consumer and Business Services for the State of Oregon ("***Director***"), acting in accordance with Oregon Revised Statutes ("***ORS***") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("***Insurance Code***"), has conducted an investigation of Regence BlueCross BlueShield of Oregon ("***Respondent***") regarding violations of the Insurance Code; and

WHEREAS Respondent wishes to resolve this matter with the Director;

NOW THEREFORE, as evidenced by the signatures subscribed in this Order, Respondent hereby CONSENTS to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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FINDINGS OF FACT

The Director FINDS that:

1. Respondent is licensed by the Director, by and through the Division of Financial Regulation, previously known as the Insurance Division (collectively the "***Division***"), as a health care service contractor. Respondent's National Association of Insurance Commissioners ("***NAIC***") company number is 54933.

2. Respondent is the third party administrator for Pioneer Educators Health Trust ("***PEHT***"), an Oregon multiple employer welfare arrangement ("***MEWA***"), NAIC

company number 12619. A MEWA is an arrangement where a group of employers pool their contributions in a self-contributing benefits plan for their employees. PEHT is a self-funded large group MEWA that, at relevant times, provided a health benefit plan to higher educational institutions located in Oregon, including the following: Lewis & Clark College; Corban University; George Fox University; Linfield College; Pacific University; Reed College; the University of Western States; and Willamette University (collectively the "***Member Institutions***"). PEHT provided benefits for approximately 1,700 employees of the Member Institutions.

3. Under a certain Administrative Services Contract between Respondent and PEHT, dated April 1, 2015 (the "***TPA Contract***"), PEHT delegated certain administrative duties to Respondent including, among other services, claims processing services and drafting and making recommendations for the 2015 health benefit plan documents for PEHT.

4. PEHT's Plan year runs from April 1st to March 31st of each year. Thus, Respondent's 2015 health benefit plan governed coverage for the period April 1, 2015 through March 31, 2016.

5. On November 14, 2014, the Division issued Oregon Insurance Division Bulletin INS 2014-2 (the "***Bulletin***"), explaining the requirements relating to health benefit plan coverage for autism spectrum disorder ("***ASD***") and other pervasive developmental disorders ("***PDDs***") , including the treatment known as applied behavioral analysis ("***ABA***"). The Bulletin provided, in part:

> An insurer may not apply a categorical exclusion (such as exclusions for developmental, social or educational therapies) that results in a denial of all ABA or other medically necessary treatment or otherwise results in the mandates[1] being effectively meaningless for ASD or PDDs.

[1] Referring to the following state and federal mental health mandates: Oregon Revised Statute ("***ORS***") 743A.190 – Oregon Mandatory Coverage for Minors with Pervasive Development Disorders ("***Oregon PDD***"); Enrolled Senate Bill 365 (2013 Legislative Session, 2013 Oregon Laws Chapter 771 ("***SB 365***"); ORS 743A.168 – Oregon Mental Health Parity ("***Oregon MHP***"); 29 U.S.C. Sec. 1185a – federal Mental

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> The Oregon PDD statute [ORS 743A.190] requires a health benefit plan to cover, for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder, all medical services that are medically necessary and are otherwise covered under the plan. The statute includes, as medical services, rehabilitation services defined to include physical therapy, occupational therapy or speech therapy services. Therefore, the mandate for medical services requires at least some of both behavioral and physical services. ABA is a behavioral service and is included among "all medical services."
>
> An insurer's denial of coverage on a basis prohibited by this bulletin may subject the insurer to enforcement measures for violation of the Oregon Insurance Code.

6. On or around October 1, 2014, prior to issuance of the Bulletin, Respondent delivered a recommended health benefit plan to PEHT for approval for the 2015 plan year. Respondent represented to PEHT that there were no benefit changes between the 2014 and 2015 health benefit plans. Contrary to Respondent's representations, the 2014 and 2015 health benefit plans did differ in at least one material respect – the 2015 health benefit plan recommended by Respondent contained a general exclusion for coverage of ABA therapy and the 2014 plan did not.

7. Almost two months after issuance of the Bulletin, on or around January 6, 2015, Respondent informed PEHT of the Bulletin and its guidance on the mandates related to coverage of ABA therapy. Respondent represented, however, that "these benefits are optional, and as a reference most of our self-funded groups are opting not to take them effective at their renewal."

8. Based on Respondent's recommendations and advice, on or around February 5, 2015 PEHT approved the 2015 health benefit plan drafted by Respondent.

9. The 2015 PEHT Medical and Vision Plan (the "***2015 Plan***"), effective on April 1, 2015, included the following office visit limitation and general categorical exclusion applicable to ASD, PDD and ABA:

Health Parity and Addition Equity Act ("***MHPAEA***").

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> **NEURODEVELOPMENTAL THERAPY**
> **Outpatient limit**: 25 visits per Claimant per Calendar Year for all outpatient neurodevelopmental therapy services.
> The Plan covers physical therapy, occupational therapy or speech therapy services to restore or improve function, for a pervasive developmental disorder, for a Claimant age 17 and under. For the purpose of this benefit, "pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability, or mental retardation.
>
> **GENERAL EXCLUSIONS**: The following are the general exclusions from coverage under the Plan.
> **Applied Behavioral Analysis treatment by any Provider for any condition**

10. With respect to the annual 25 visit limitation for neurodevelopmental therapy, the 2015 Plan did not impose the same or a similar annual visit limitation for substantially all (at least two –thirds) of the medical or surgical benefits covered under the 2015 Plan.

11. Based on Respondent's representations that there were no benefit changes between the 2014 and 2015 health benefit plans, PEHT did not submit the 2015 Plan to the Division for approval.

12. PEHT delivered the unapproved 2015 Plan to the Member Institutions for distribution to enrollees in the plan. The 2015 Plan was available to enrollees and the general public on the websites of at least three of the Member Institutions until approximately December 2016.

13. Respondent used the unapproved 2015 Plan to process claims between April 1, 2015 and on or around September 30, 2015.

14. Respondent published the 2015 plan externally on the member portal on or around August 31, 2015.

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I. Denial of Preauthorization Requests for ABA Therapy

15. The Oregon consumer identified herein as "***HS***" was an enrollee in the 2015 Plan.

16. In or around July 2015, HS called Respondent and made a number of verbal preauthorization requests for coverage of ABA therapy for her minor dependent that had been diagnosed with ASD and prescribed ABA therapy as medically necessary treatment. In response to each such request, Respondent verbally represented to HS that ABA therapy was not a covered benefit. Respondent further represented to HS that PEHT was exempt from the mandates for ABA therapy explained in the Bulletin.

17. On July 23, 2015, HS submitted a written preauthorization request to Respondent, via facsimile, seeking prior authorization for coverage of ABA therapy.

18. The 2015 Plan provides that responses to preauthorization requests will be provided, in writing, within 15 calendar days from receipt of the preauthorization request.

19. HS did not receive a written response to her July 23, 2015 preauthorization request within the 15 day timeframe provided for in the 2015 Plan, or by August 7, 2015. Accordingly, on August 18, 2015, HS mailed Respondent the same preauthorization request submitted on July 23rd, and again requested a written response to the same.

20. On or around August 19, 2015, Respondent mailed HS a letter denying her preauthorization request for coverage of ABA therapy. The denial letter stated that "your plan does not cover Applied Behavioral Analysis treatment. Please refer to Specific Exclusions in the current benefit book where Applied Behavioral Analysis treatment by any provider for any condition is listed as excluded from coverage. We are unable to provide preauthorization for services that are not covered."

21. HS sought an appeal of her preauthorization request denial from Respondent.

22. On September 4, 2015 Respondent issued a letter denying HS's request for an appeal, stating "we are unable to accept this appeal since preauthorization is not required

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for services that are not covered…According to page 29 of the Pioneer Educators Health Trust Summary Plan Description, ABA treatment by any provider for any condition is listed as a specific exclusion."

23. On or around August 2, 2015, HS filed a complaint with the Division regarding the verbal preauthorization denials she received from Respondent and the general exclusion for ABA therapy coverage contained in the 2015 Plan.

24. The Division contacted Respondent and PEHT regarding the complaint filed by HS, and advised that the 2015 Plan was not in compliance with state and federal mental health parity laws.

25. In responding to the HS complaint, Respondent represented to PEHT on September 9, 2015 that "PEHT as a self-funded MEWA has the right to exclude state mandates…ABA is [a choice]. The ABA therapy benefit in both Washington and Oregon only applies to health plans issued by a health insurer that are subject to state law, of which PEHT is not."

26. Despite Respondent's representations, on or around September 30, 2015, PEHT directed Respondent to include ABA therapy as a covered service.

II. Denial of ABA Therapy Claim

27. The Oregon consumer identified herein as "***MM***" was an enrollee in the PEHT health benefit plan that was effective from April 1, 2014 through March 31, 2015 (the "***2014 Plan***"). The 2014 Plan did not include the same ABA exclusion or annual 25 visit limitation for neurodevelopmental therapy treatments of ASD that were improperly included in the 2015 Plan.

28. Respondent was the third party administrator for the 2014 Plan.

29. In October 2015, after PEHT directed Respondent to process post-Bulletin claims for ABA therapy as a covered service, MM submitted a claim to Respondent for coverage of ABA therapy for her minor dependent. The claim was for services received

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by MM's dependent on or around March 18, 2015, after issuance of the Bulletin clarifying the ABA therapy coverage mandates.

30. Respondent denied the claim, despite the lack of a specific exclusion for ABA therapy in the 2014, and despite the mandates for ABA therapy discussed in the Bulletin.

31. Following denial of MM's claim, Respondent has acknowledged that PEHT is subject to the ABA therapy mandates discussed in the Bulletin. Respondent has failed, however, to reprocess or re-adjudicate MM's claim for ABA therapy that Respondent improperly denied. Respondent did, however, approve subsequent claims for coverage of ABA therapy submitted by MM.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

32. Respondent is a "carrier" under ORS 743B.005(5), and a third party administrator under ORS 744.700 *et seq.*, and is subject to regulation by the Director.

33. Notwithstanding PEHT's status as a self-funded large group MEWA, under ORS 750.333(1) PEHT is subject to various provisions of the Insurance Code, including but not limited to the requirements of 743A.168 (Oregon MHP) and ORS 743A.190 (Oregon PDD).

34. Under ORS 743A.168, a group health insurance policy must provide coverage for treatment for mental health conditions at the same level as, and subject to limitations no more restrictive than, treatments for other medical or surgical conditions.

35. Under Oregon Administrative Rule ("***OAR***") 836-053-1405(2)(c), if an insurer applies annual limits to treatment of mental health conditions, the limits must comply with the "predominantly equal" to and "substantially all" tests set forth in the MHPAEA and implementing regulations at 45 CFR 146.136 and 147.160.

36. Under MHPAEA, an annual visit limitation for the treatment of mental health conditions is prohibited unless an insurer can establish that the limitation is not more

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restrictive than the limitation that the insurer applies to substantially all (at least two – thirds) of medical or surgical benefits in the same classification. 29 U.S.C. Sec. 1185(a); 29 CFR 2590.712.

37. Under ORS 743A.190, a health benefit plan must provide coverage for a child diagnosed with ASD all medically necessary services that are otherwise covered under the plan.

38. The annual office visit limitation for Neurodevelopmental Therapy (physical, occupational, and speech therapy) in Respondent's 2015 Plan, as more fully discussed in Paragraph 9 above, violated ORS 743A.168 and OAR 836-053-1405(2)(c).

39. The general exclusion of coverage for ABA therapy in Respondent's 2015 Plan, as more fully discussed in Paragraph 9 above, violated ORS 743A.168.

40. Under ORS 746.075(2)(a), a person may not, in connection with the offer or sale of insurance, engage, directly or indirectly, in the making, issuing, circulating, or causing to be made, issued or circulated, any statement misrepresenting the terms of any policy issued or to be issued, of the benefits or advantages therein.

41. Respondent violated ORS 746.075(2)(a) when Respondent:

A. Misrepresented to PEHT that there were no benefit changes between the 2014 and 2015 health benefit plans, thereby causing PEHT to issue the unlawful, unapproved 2015 Plan recommended by Respondent; and

B. Misrepresented to PEHT that the requirements for coverage of treatments relating to ASD and PDD diagnoses, including ABA therapy, were optional to PEHT, and thus that PEHT did not need to include coverage for such services in the 2015 Plan.

42. Under ORS 746.110, no person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public…a statement containing any assertion, representation or statement with respect to the business of insurance or with

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respect to any person in the conduct of the insurance business, which is untrue, deceptive, or misleading.

43. Respondent violated ORS 746.110 when Respondent made the following untrue, deceptive, or misleading statements:

A. The statement made to PEHT on or around January 6, 2015 that the mandates for ABA therapy described in the Bulletin were optional benefits with respect to PEHT, as a self-funded group plan;

B. The statement made to HS in or around July 2015 that PEHT was exempt from the mandates for ABA therapy described in the Bulletin; and

C. The statement made to PEHT on September 9, 2015 that PEHT has the right to exclude state mandates, that ABA is a choice, and that PEHT is not subject to state laws.

44. Under ORS 746.230(1), no person shall commit or perform any of the following unfair claim settlement practices, among others: (d) refusing to pay claims without conducting a reasonable investigation based on all available information; (f) not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear.

45. Respondent violated ORS 746.230(1) (d) and (f) when it denied MM's claim for ABA therapy despite the lack of any basis for the denial in the 2014 Plan, and despite the clear guidance set forth in the Bulletin regarding ABA therapy mandates, and despite the direction from PEHT to approve claims for ABA therapy.

46. Under ORS 731.988(1), the Director may assess a civil penalty of up to $10,000 against any person that violates a provision of the Insurance Code or any lawful rule or final order of the Director. Each violation is a separate offense.

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ORDERS

Now therefore, the Director issues the following Orders:

47. As authorized by ORS 731.252(1), the Director ORDERS Respondent to CEASE AND DESIST from violating any provision of the Insurance Code or the administrative rules promulgated thereunder.

48. As authorized by ORS 731.988(1), the Director hereby assesses CIVIL PENALTIES against Respondent in the total amount of One Hundred Thousand Dollars ($100,000), as follows:

A. A CIVIL PENALTY of Thirty Thousand Dollars ($30,000) for violations of ORS 746.075(2)(a);

B. A CIVIL PENALTY of Forty Thousand Dollars ($40,000) for violations of ORS 746.110; and

C. A CIVIL PENALTY of Thirty Thousand Dollars ($30,000) for violations of ORS 746.230(1)(d) and (f).

49. This Order is a "Final Order" under ORS 183.310(6)(b). Subject to that provision, entry of this Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Director under Oregon law to enforce this Order, for violations of this Order, for conduct or actions of Respondent that are not covered by this Order, or against any party not covered by this Order.

SO ORDERED this ____day of _____, 2017.

PATRICK M. ALLEN, Director
Department of Consumer and Business Services

_____
David C. Tatman, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, _____, state that I am an officer of Regence BlueCross BlueShield of Oregon ("***Respondent***"), and that I am authorized to act on its behalf; that I have read the foregoing Order and that I know and fully understand the contents hereof; that I have been advised of Respondent's right to a hearing in this matter; that Respondent has been represented by counsel in this matter; that Respondent voluntarily and without any force or duress, consents to the entry of this Order, expressly waiving any right to a hearing in this matter; that Respondent executes this Order as a settlement of the matters referred to in the foregoing Order; that Respondent understands that the Director reserves the right to take further actions to enforce this Order or to take appropriate action upon discovery of other violations of the Insurance Code by Respondent, and; that Respondent will fully comply with the terms and conditions stated herein.

Respondent understands that this Order is a public document.

By: _____
Signature

By: _____
Printed Name

Office Held: _____

State of OREGON
County of _____

There appeared before me this ___day of _____, 2017, _____, and stated that he/she was and is an officer of Respondent, and that he/she is authorized and empowered to sign this Order on behalf of Respondent, and to bind it to the terms hereof.

_____
Notary Public - State of Oregon

Approved as to form:

_____ _____
Date

Attorney for Respondent

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