Support SB728: Includes Insurance Under the UTPA

Testimony to Oregon Senate Judiciary Committee by

Paul Terdal

March 5, 2019

Introduction – Paul Terdal

- Resident of Northwest Portland, Senate District 18 / House District 36
- 25+ years of professional experience in regulated environments
  - Lead critical projects; develop business processes, systems for regulatory compliance
    - Nuclear, healthcare, communications, education, commercial fisheries
  - MBA, Yale School of Management
    - John M. Olin Fellow in the Study of Markets and Regulatory Behavior
- Volunteer consumer advocate assisting families with insurance appeals related to autism and related medical / mental health coverage
  - Assisted more than 100 families with insurance denials, coverage issues
- Lead consumer advocate on key insurance legislation
  - SB414 (2013) – Insurance Commissioner's Restitution Authority
  - SB365 (2013) and SB696 (2015) – Autism Health Insurance Reform

A few of the insurance issues I've encountered….

- When consumers successfully appealed denials of autism treatment with help from a participating physician, an insurer prohibited the physician from making any further referrals
- An insurer told U.S. District Court that it had structured denials to evade the legally mandated External Review process for the purpose of provoking litigation
  - The same insurer acknowledged in a sworn statement that it continued denying treatment as "experimental" after its experts concluded that it was proven while it evaluated cost and pricing
- An insurer provided inaccurate claims about research findings into a treatment. When consumers asked for copies of the reports, the insurer refused
  - We found the reports ourselves – and they directly contradicted the insurers claims
- After DCBS issued bulletins requiring all insurers to provide coverage of treatment for autism, a plan added a specific exclusion of the mandated coverage
  - It falsely claimed to be exempt from state regulation
  - Refused to provide the consumer with a written denial of coverage

SB414 (2013) granted the Insurance Commissioner restitution *authority* …

- SB414 (2013) created a new provision in ORS 731.256:
  - (2) As part of or in addition to any action or proceeding the director institutes against an insurer under subsection (1) of this section, the director may:
  - (a) Seek *restitution* on a consumers behalf for *actual damages the consumer suffers as a result of the insurers violation* of a provision of the Insurance Code or applicable federal law or the insurers breach of an insurance contract or policy the insurer has with the consumer; and
  - (b) Seek other equitable relief the director deems appropriate under the circumstances.

- Black's Law Dictionary Definition of "Actual Damages":
  - Actual damages. Real, substantial and just damages, or the amount awarded to a complainant in compensation for his actual and real loss or injury, as opposed to on the one hand "nominal" damages, and on the other to "exemplary" or "punitive" damages. Synonymous with "compensatory damages" and with "general damages."

- Restitution under SB414 is a form of civil penalty tied to the harm resulting from illegal activity – *it is only available as part of an enforcement action by DCBS*

… but there are no Laws or Administrative Rules governing the Complaints and Enforcement ***process***

- While the Consumer Advocacy unit is eager to help consumers, there are no Laws or Administrative Rules on *management of complaints* about illegal conduct
  - Laws require DCBS to record and report on complaints….
    - ORS 731.288: Director shall record complaints and consider them before issuing licenses
    - ORS 731.264: Makes complaints confidential, and calls for an annual statistical report
  - … but nothing describes investigation of complaints

- There is no transparent process for consumers to have their complaints heard, receive a decision on the merits, and resolve appeals
  - Many complaints have lingered for years, under review pending a decision on enforcement – with no status report or communication to the consumer
  - DCBS has asserted that consumers have no right to appeal or protest decisions regarding whether or how much restitution to provide under SB414
  - In recent cases, consumers haven't even been consulted about restitution

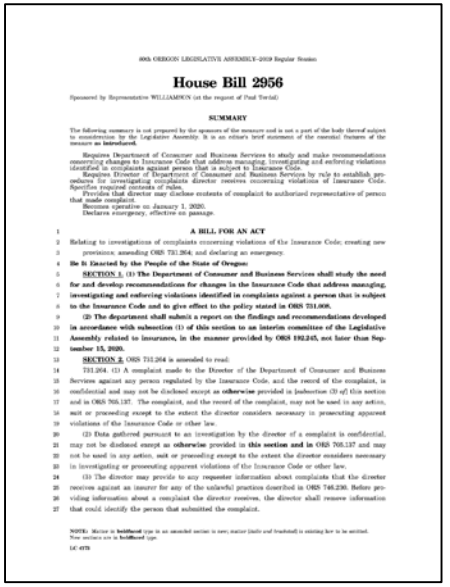
- DCBS encourages consumers to retain their own attorneys and pursue litigation rather than waiting for enforcement action or restitution

A restitution attempt

- I filed consumer complaints in 2011 and 2012 regarding issues related to coverage of treatment for autism
- For years, the Insurance Division assured me that they were working on my complaints and asked me to be patient
- When my 6-year statute of limitations was about to expire, the Division advised me that it needed a little more time.
  - I filed a lawsuit to preserve my rights while the Division finished its work
- Division attorneys urged me not to agree to any settlements that required me to withdraw my complaints with the Division
- I learned that the Division was taking enforcement action in my case from the news media
  - Two reporters contacted me for comment after seeing a press release
  - The Division released information about my complaint, identifying me by name
- One of the largest civil penalties ever assessed against an individual insurer – but no restitution, and no order to pay my claims

Two Alternate Bills – HB2421 and HB2956

- HB2956 requires DCBS to:
  - Establish procedures by rule for investigating complaints
  - Study and make recommendations concerning changes to Insurance Code that address managing, investigating and enforcing violations



80th OREGON LEGISLATIVE ASSEMBLY–2019 Regular Session

House Bill 2956

Sponsored by Representative WILLIAMSON (at the request of Paul Terdal)

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 as introduced.

Requires Department of Consumer and Business Services to study and make recommendations concerning changes to Insurance Code that address managing, investigating and enforcing violations identified in complaints against person that is subject to Insurance Code.

Requires Director of Department of Consumer and Business Services by rule to establish procedures for investigating complaints director receives concerning violations of Insurance Code. Specifies required contents of rules.

Provides that director may disclose contents of complaint to authorized representative of person that made complaint.

Becomes operative on January 1, 2020.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to investigations of complaints concerning violations of the Insurance Code; creating new provisions; amending ORS 731.264; and declaring an emergency.

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

SECTION 1. (1) **The Department of Consumer and Business Services shall study the need for and develop recommendations for changes in the Insurance Code that address managing, investigating and enforcing violations identified in complaints against a person that is subject to the Insurance Code and to give effect to the policy stated in ORS 731.008.**

(2) The department shall submit a report on the findings and recommendations developed in accordance with subsection (1) of this section to an interim committee of the Legislative Assembly related to insurance, in the manner provided by ORS 192.245, not later than September 15, 2020.

SECTION 2. ORS 731.264 is amended to read:

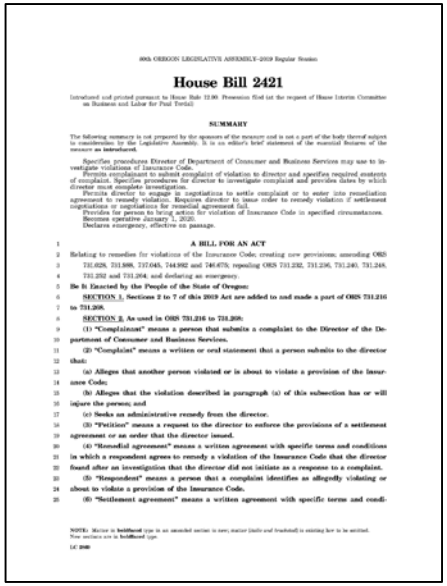
731.264. (1) A complaint made to the Director of the Department of Consumer and Business Services against any person regulated by the Insurance Code, and the record of the complaint, is confidential and may not be disclosed except as **otherwise** provided in [*subsection (3) of*] this section and in ORS 705.137. The complaint, and the record of the complaint, may not be used in any action, suit or proceeding except to the extent the director considers necessary in prosecuting apparent violations of the Insurance Code or other law.

(2) Data gathered pursuant to an investigation by the director of a complaint is confidential, may not be disclosed except as **otherwise** provided in **this section and in** ORS 705.137 and may not be used in any action, suit or proceeding except to the extent the director considers necessary in investigating or prosecuting apparent violations of the Insurance Code or other law.

(3) The director may provide to any requester information about complaints that the director receives against an insurer for any of the unlawful practices described in ORS 746.230. Before providing information about a complaint the director receives, the director shall remove information that could identify the person that submitted the complaint.

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.

LC 4178



80th OREGON LEGISLATIVE ASSEMBLY–2019 Regular Session

House Bill 2421

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of House Interim Committee on Business and Labor for Paul Terdal)

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 as introduced.

Specifies procedures Director of Department of Consumer and Business Services may use to investigate violations of Insurance Code.

Permits complainant to submit complaint of violation to director and specifies required contents of complaint. Specifies procedures for director to investigate complaint and provides dates by which director must complete investigation.

Permits director to engage in negotiations to settle complaint or to enter into remediation agreement to remedy violation. Requires director to issue order to remedy violation if settlement negotiations or negotiations for remedial agreement fail.

Provides for person to bring action for violation of Insurance Code in specified circumstances.

Becomes operative January 1, 2020.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to remedies for violations of the Insurance Code; creating new provisions; amending ORS 731.028, 731.988, 737.045, 744.992 and 746.078; repealing ORS 731.232, 731.236, 731.240, 731.248, 731.252 and 731.264; and declaring an emergency.

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

SECTION 1. Sections 2 to 7 of this 2019 Act are added to and made a part of ORS 731.216 to 731.308.

SECTION 2. As used in ORS 731.216 to 731.269:

(1) "Complainant" means a person that submits a complaint to the Director of the Department of Consumer and Business Services.

(2) "Complaint" means a written or oral statement that a person submits to the director that:

(a) Alleges that another person violated or is about to violate a provision of the Insurance Code;

(b) Alleges that the violation described in paragraph (a) of this subsection has or will injure the person; and

(c) Seeks an administrative remedy from the director.

(3) "Petition" means a request to the director to enforce the provisions of a settlement agreement or an order that the director issued.

(4) "Remedial agreement" means a written agreement with specific terms and conditions in which a respondent agrees to remedy a violation of the Insurance Code that the director found after an investigation that the director did not initiate as a response to a complaint.

(5) "Respondent" means a person that a complaint identifies as allegedly violating or about to violate a provision of the Insurance Code.

(6) "Settlement agreement" means a written agreement with specific terms and condi-

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.

LC 2040

- HB2421 establishes specific procedures for enforcement
  - Based on the process BOLI uses to investigate civil rights complaints
  - Consumer may pursue private right of action if DCBS is unable to resolve a complaint in a timely manner
  - New version of HB2858 from 2017

Discussion - Conclusion

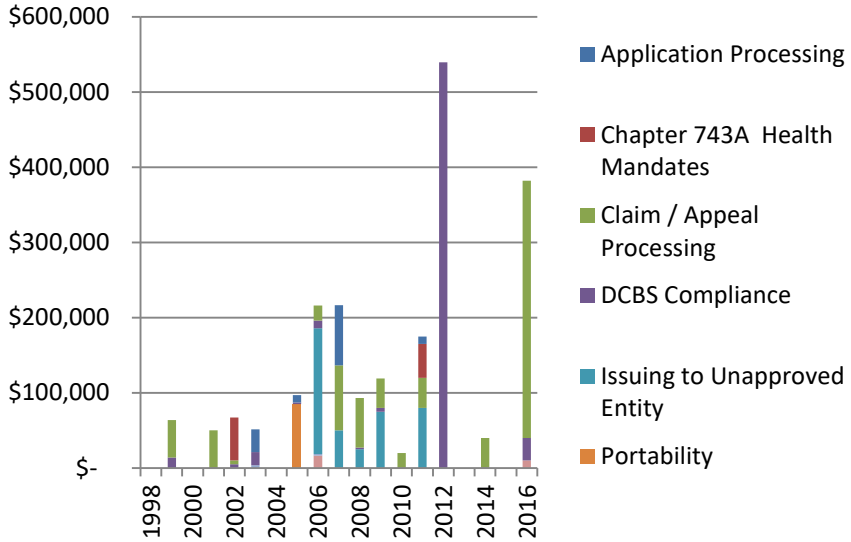
- DCBS has the authority and the mandate to enforce the law for the protection of consumers – but not the process
  - Current enforcement practice addresses only broad issues involving many consumers – no real mechanism to deploy restitution authority for individuals
  - Consumers have little engagement even about restitution for their own cases

- Some issues probably should be litigated – but the tools are lacking
  - DCBS tends to enforce basic insurance procedure violations, not complex issues
  - Litigation is extraordinarily expensive, with little return – only the wealthy can afford justice
  - Limited to breach of contract – not violation of rights under insurance code

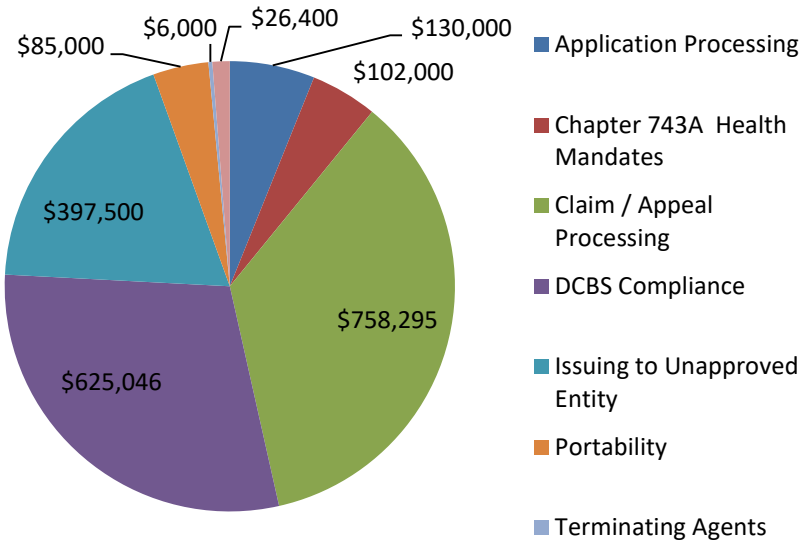
Supplemental Materials

Marketplace enforcement actions from Consumer Complaints are rare, and penalties historically mild

Health Insurer Financial Penalties by Violation, Year



Health Insurer Financial Penalties by Violation, Since 1998



- Insurance Division receives 700 – 900 Consumer Complaints against health insurers each year
- Since 1998, only 4 enforcement actions for failure to provide mandated health coverage
  - Most enforcement actions involve compliance with insurance procedures
  - Financial penalties average $100k / year
- See TerdalP Report OID Market Enforce 1998-2016 2017-03-15.pdf for all lines of insurance

Source: http://dfr.oregon.gov/laws-rules/Pages/notices-orders.aspx

A Case Study in "Actual Damages" (1 of 2)

- 5 year old child with autism – physician recommended intensive ABA therapy
  - Insurer denied coverage solely on the claim that the provider was allegedly unqualified
    - Provider was approved by DHS as required by ORS 743A.168(5)(a) ***and*** grandfathered to practice ABA under 2013 Oregon Laws Chap 771(4)
    - Insurer had no alternative providers in network
  - Insurance Division called the Insurer in July 2014 and advised them that their denial was unlawful – Insurer responded that it would not comply without a written order
  - In November 2014, Bulletins INS 2014-1 and 2014-2 expressly prohibited Insurer's basis for denial, with a supporting opinion from the Department of Justice
- Consumer suffered real, substantial damages as a result of the insurers violation – see letter on next slide
  - Forced to sell house and car to pay for treatment that should have been covered
  - Still couldn't afford full amount of recommended treatment – so child missed the prime age window for intervention. Child lost developmental milestones and will need more substantial care, for more time, to attempt to make up lost ground
  - Moved across state to Portland and changed job to get an insurance plan willing to comply with the law
- After nearly four years of investigation, complaint remains active but no enforcement action has been taken or restitution provided

A Case Study in "Actual Damages" (2 of 2)

- The parents provided this letter to the Judiciary Committee in 2015 to describe the impact the Insurer's violation had upon them in their own words:

9/28/15

To Whom it May Concern:

Although we followed the steps we were supposed to, the claims and the appeals meant nothing. We sold our house to pay for therapies. We sold a car to pay for doctor's visits. We took jobs in different cities to obtain the best benefits possible. Over and over, we have sacrificed and adapted to help our child recover as much as possible.

Two years ago, we tried to start ABA (applied behavioral analysis) therapy. We had started coverage under a different insurance plan, but our insurance changed and we started the approval process over. Because therapy was already under way, we didn't want to stop while we waited for them to get through the rounds of appeal. We were told countless times that it would be resolved shortly. We were denied services based on untrue claims that our provider wasn't licensed. Seeing that it was unjust, we continued to press on and seek help in fighting the denials. We continued therapy minimally throughout the year as we could afford. It was much less than what we should have done to achieve maximum recovery of lost skills.

At the end of the year, the recovery wasn't substantial enough. I had to take a job in Portland for better benefits, hoping that it would open the door to better therapies. Six weeks into that job, I had to switch to yet another job to work at the school my child attended so I could help facilitate care. Still, no services, no restitution. Finally, this year I embarked in my own graduate studies to help secure a long term future for our family. But, one week in, I received a report about our child's skill levels and across the board they were too low. Because we were not able to give the therapy needed after insurance denied it, I had to take a leave of absence to oversee the new therapy schedule and to try and find a job to pay for it. We have absorbed and weathered loss after loss as a family. We are always fighting. We want only what every parent wants-to provide for their child what he/she needs. Our only limitations to helping our child has been what insurance would and would not cover. I find this odd and disheartening as I am paying my premium every month, so why aren't they dong their part?

We are hard working, intelligent, and dedicated people who serve and love others for a living. We are asking for justice here. Please remember this story and the hundreds and thousands of other untold stories as you consider this important matter.

Respectfully,

A Mother and a Father

DCBS Web Page: "Once you file a complaint"

Most complaints resolved within 60 days

- We handle complaints about mortgage lenders, loan originators, finance service professionals, and most lines of insurance. This includes auto, homeowner, health, life, annuities, long-term care, and even pet.

Once we receive a complaint, an advocate will:

- Let you know in writing that we received your complaint
- Send a copy of your complaint to the insurance company, agent, or both
- Obtain a detailed response from the company, agent, or both
- Analyze the response and any supporting documents (the company or agent must respond within three weeks)
- Determine whether more information is needed or there is a possible violation
- Advise you of our findings

How long will it take?

- Most complaints are resolved within 60 days but it depends on the type of complaint. Sometimes it is just a few days or weeks.

Source: http://dfr.oregon.gov/gethelp/Pages/after-filing-complaint.aspx

DCBS Web Page: "What can the division do?"

We can:

- Educate you about your rights.
- Resolve issues before they lead to further harm.
- Fine companies or agents that break the law or revoke their licenses.
- Tell you whether a company or agent is licensed in Oregon.
- Educate you about a company's complaint history and its financial soundness.
- Detect areas of that law that need to changed.

Results vary from providing information to getting a claim paid. Consumers who are unhappy with the results we obtain may want to contact an attorney.

We cannot:

- Act as your attorney.
- Recommend an insurance company or agent.
- Force a company to pay claims, to cover a medical procedure, or to refund premiums if the company is following the law and its insurance contract.
- Resolve issues outside our jurisdiction. For example, the issue might be who is at fault or how much should be paid as a result of a car accident. We will make sure the insurance companies follow the law and you know your rights and options. However, the court system determines fault and damages rest with the court system.

Source: http://dfr.oregon.gov/gethelp/Pages/after-filing-complaint.aspx