February 11, 2025

From: Paul Terdal
To: House Committee on Behavioral Health and Healthcare
Re: Support for HB2023 – Oregon Insurance Commissioner Bulletins on Mental Health Parity and ABA Therapy from 2014

Dear Chair Nosse and Members of the Committee,

This memorandum and package of materials is to supplement my testimony in support of HB2023.

After the Oregon legislature unanimously passed SB365 in 2013, numerous legal questions remained about the interaction between that new Oregon law and existing state and federal legislation regarding health coverage requirements for autism and other behavioral health conditions. Many of these issues were resolved in August 2014 by a U.S. District Court decision in A.F. v Providence, which confirmed that Applied Behavior Analysis (ABA) therapy was a medical service already required for coverage under existing Oregon law (ORS 743A.190 and ORS 743A.168) and that the Federal Mental Health Parity and Addiction Equity Act restricted insurers' ability to limit or exclude coverage.

In the wake of that decision, the Oregon Division of Financial Regulation issued two bulletins, INS 2014-1: Mental Health Parity and INS 2014-2: Autism Spectrum Disorder; Applied Behavior Analysis Therapy with a detailed analysis of the interplay between these state and federal statutes. These bulletins were supported by a public-facing legal opinion from the Oregon Department of Justice.

Because these documents are important for the legislative record in understanding and interpreting HB2023 and the original bill (SB365(2013)) that it amends, I am attaching them all to this memorandum:

1. Insurance Commissioner's 11/14/2014 cover letter announcing the bulletins
2. Frequently Asked Questions related to Mental Health Parity and Autism Spectrum Disorder Bulletins
3. Insurance Division's 11/14/2014 Press Release announcing the bulletins
4. Bulletin INS 2014-1 Mental Health Parity
5. Bulletin INS 2014-2 Autism Spectrum Disorder; Applied Behavior Analysis Therapy
6. Oregon DoJ Opinion 11/14/2014 Statutory Questions Related to Applied Behavior Analysis (ABA) and Mental Health Parity Bulletins
7. AF v Providence Opinion and Order, 8/8/2014

Sincerely,

Paul Terdal

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

November 14, 2014

To All Persons Interested in Mental Health Parity in Oregon:

Today, the Insurance Division of the Department of Consumer and Business Services issued two bulletins that clarify the division's understanding of the requirement that health insurers including health care service contractors, in Oregon provide coverage of mental health conditions. The first bulletin, INS 2014-1 relates to mental health parity and the division's expectations about how insurers will provide benefits generally for all mental health and nervous conditions. The second bulletin, INS 2014-2 provides more specific information about expectations related to a particular mental health condition, autism spectrum disorder (ASD). This bulletin also includes information about coverage of treatment for ASD known as applied behavior analysis (ABA).

To provide immediate clarification for recent and ongoing cases, these bulletins apply to claims related to a mental or nervous condition submitted to carriers on or after August 8, 2014, which is the date the U.S. District Court for the District of Oregon adjudicated the legal arguments in the *A.F. v. Providence* lawsuit. The division expects that all such claims submitted to carriers on or after that date will be handled by insurers in a manner that conforms to the expectations of these bulletins. The division continues to analyze its approach to enforcement for claims related to a mental or nervous condition submitted prior to August 8, 2014, and this analysis will include collection and evaluation of additional data and information regarding claims practices and licensure issues.

The bulletins look at the interrelationship of three statutes and rules and regulations adopted by state and federal agencies to implement the provisions of these laws: ORS 743A.168, Oregon's mental health parity statute; ORS 743A.190, related to pervasive development disability; and the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act, 29 U.S.C. 1185a (MHPAEA). Of particular concern is the use of blanket exclusions that effectively negate the requirements of the statutory mental health parity mandates that have been in operation since these statutes were last amended in 2005, 2007, and 2008 respectively.

In addition to these bulletins, the division is providing a Q & A that answers specific questions that have been asked about the division's position as set out in the bulletins. For additional information about legal questions related to the bulletins, the division is furnishing a legal opinion written by the Oregon Department of Justice.

In order to assure that insurers are compliant with division's expectations under these laws as set forth in the bulletins, the division will examine any contract language that includes blanket or categorical exclusions. The division will contact insurers if changes are required. For existing

contracts and for plans issued for the 2015 plan year, insurers are directed to administer the plans consistent with the law as explained in the bulletins. Basically, an insurer may not interpret a blanket or categorical exclusion so as to deny all claims for services that may be medically necessary and mandated to be covered in parity by one of the statutes mentioned above, regardless of the contract language. An insurer also must recognize the definition of "mental health condition" as defined in the rule on the basis of either the DSM IV or the DSM 5, regardless of any contract language that specifies only one or the other.

In addition to issuing these bulletins, the division has adopted a temporary change to Oregon's mental health parity rule to include references to the DSM 5 in defining a mental health condition. This change will provide clarity in the rule for providers and insurers during the period of transition from use of the DSM IV to complete transition to the DSM 5. This technical update of the rule takes effect immediately and will continue in effect for up to 180 days or until a permanent rule is adopted. The division will begin a permanent rulemaking process immediately to examine all of the rules related to mental health parity and pervasive developmental disability to determine whether permanent changes are needed to further clarify the interpretations of the bulletins. During that process, the change to include the DSM 5 references will also be made permanent.

Questions about this letter related to 2014 or 2015 plans should be directed to Annette Boyce, Manager of the Rates and Forms Section. Questions about review of claims and benefit denials should be directed to Brian Fordham, Manager of Market Regulation Section.

Sincerely,

Laura N. Cali, FCAS, MAAA
Insurance Commissioner

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

Frequently Asked Questions related to Mental Health Parity and Autism Spectrum Disorder Bulletins

(November 14, 2014)

The Insurance Division has received a number of questions about bulletins INS 2014-1 and INS 2014-2. The answers below address those questions. Answers to questions of a legal nature are addressed in the Department of Justice public opinion released today along with the bulletins.

Reliance on Other States' Regulatory Provisions

1. Why does OID cite other states' statutes and court cases in these bulletins?

   The OID has requested and received advice from the Department of Justice related to the ability to rely on federal and other states' judicial decisions. In addition, the division has noted changes in regulatory approaches in other states and jurisdictions that have statutes similar to ORS 743A.168 and 743A.190 and that are also subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) provisions. Although the actions of other states' insurance regulatory bodies do not have any legal precedence or authority over Oregon, they do highlight how other regulators are interpreting similar laws. These actions by other state regulators are also indicative of policy trends, changes in opinions about certain treatments, observations about potentially discriminatory treatment, etc. Staying abreast of policy trends in other states is an important way to provide more uniformity in insurance regulation.

Independent Review Organizations

1. How does OID use IRO decisions in assessing whether an insurer is following the law?

   The Insurance Division examines IRO decisions to determine if a trend or pattern indicates that an insurer may be continuing to deny benefits on the same basis even though those denials are continually overturned by the IROs. It may indicate a need for the insurer to review its process or basis for denials to determine whether the denial of benefits continues to be valid. Insurers should also periodically review these records for the same reason.

2. Are insurers expected to be aware of IRO decisions other than their own?

   No, although the information is readily available from the Insurance Division. The OID can provide information about trends or patterns emanating from IRO decisions if that is useful to insurers.

3. How does the division monitor IRO decisions?

   Currently, the division reviews IRO decisions when received. If an apparent pattern of IRO decisions overturning a denial of benefit for the same treatment appears, the division will look more closely into the insurer's denials to determine whether there is a pattern of denials that conflicts with legal requirements.

4. Are IRO decisions precedents?

   No.

Information about Covered Services

1. Are insurer claims determination policies expected to be transparent and consistent? If so, how?

   Yes. Claims determination policies should be written, and a member or provider should be able to easily predict coverage in most cases without having to submit a claim.

2. May insurers provide oral information about covered services?

   Yes, but if the insurer is essentially denying a benefit, it needs to follow up with written information about the insurer's appeal process and the opportunity for additional review.

ABA Services

1. Does Oregon's Essential Health Benefit (EHB) benchmark plan, the PacificSource Codeduct Value plan (the "Benchmark Plan"), require coverage of ABA?

   Yes.

2. May age be a relevant clinical determinant when reviewing proposed ABA treatment?

   Yes. Proposed ABA treatment should always be reviewed and determined on the basis of medical necessity. If appropriate to that determination, age may be considered. However, an insurer may not categorically deny ABA treatment on the basis of age of the patient.

3. Must carriers pay for 25 hours per week even if fewer hours of service are provided?

   No, an insurer is only required to pay for services provided.

Cost Issues

1. Do the bulletins impose a new mandate under the ACA?

   No

2. May insurers adjust their filed rates to reflect these bulletins?

   No. The rate review process for 2015 plans is complete and open enrollment begins Nov. 15. It is not possible to adjust rates at this point in the process. Insurers will be able to consider any increased costs in developing 2016 rates.

ABA Providers

1. May an insurer restrict its in-network panel of ABA providers?

   Yes. An insurer may require credentialing of ABA providers. Insurers must accept grandfathered providers (under Senate Bill 365) if they meet credentialing requirements. Although an insurer may restrict its panel of ABA providers, the insurer must ensure that the in-network panel is adequate to meet the needs of its insureds.

2. Must an insurer have ABA providers on as part of its contracted network?

   Yes, but in light of passage of Senate Bill 365, the insurer may need to build ABA providers into the insurer's network.

3. May an insurer restrict covered ABA services to those provided by licensed or registered providers?

   Yes, depending on the credentialing requirements for the insurer. However, until Jan. 1, 2016, an insurer must treat a provider grandfathered under the terms of Senate Bill 365 as a licensed provider.

4. May an insurer restrict covered ABA services to those provided by providers it has credentialed?

   Yes, as long as the insurer's credentialing requirements do not result in having no providers. This would result in a negation of the mental health mandate and as such would not be allowed.

5. Does an insurer need to create credentialing standards for ABA providers?

   Yes. Credentialing standards for ABA providers should be developed in the same manner as other provider credentialing standards. The credentialing standards need to take into account the status of grandfathered providers under Senate Bill 365 and consider them the same as a licensed provider throughout the grandfather period.

Applicability

1. To what mental health conditions do these bulletins apply?

   These bulletins apply to all mental health and nervous conditions as defined in OAR 836-053-1404. This means that with very limited exceptions as set out in that rule, all conditions in the DSM-IV or DSM 5 must be covered.

2. What is the applicability date of the bulletins?

   The mandates discussed in these bulletins took effect on different dates. These bulletins set forth the division's interpretation of the mandates and the expectations for insurers in providing coverage as required by the mandates. To provide immediate clarification, these bulletins apply to claims related to a mental or nervous condition submitted to carriers on or after August 8, 2014.

3. Do the limitations on exclusions and conditions apply to all mental health conditions?

   Yes.

4. How will the division apply these bulletins to pending consumer complaints?

   The division will work with insurers to assess past denials and determine a plan to address past and pending benefit denials.

5. Do the restrictions/requirements of these bulletins apply to policy forms already filed with the division for 2015 plan years?

   Yes.

6. Does this bulletin mean that all medically necessary treatment for a mental health condition must be covered?

   No. An insurer must make a determination about whether a treatment is medically necessary. OAR 836-053-1405 requires the insurer to cover all medically necessary treatments. An insurer may find that a treatment is not medically necessary, and then the consumer could appeal to an IRO to reexamine medical necessity. ORS 743A.168 does include some limitations on the coverage required. However, even though these limitations or exclusions are allowed under state law, insurers must be mindful of the restrictions on these exclusions or limitations under the MHPAEA or other mandates.

Salem - The Oregon Department of Consumer and Business Services, Insurance Division today issued two bulletins that require insurers to cover treatment of autism and other mental health conditions, just as insurers cover treatment for physical health conditions.

The bulletins take effect retroactively to Aug. 8, 2014, the same day the U.S. District Court for the District of Oregon ruled that Providence must pay for Applied Behavior Analysis (ABA) therapy as a treatment for autism. Many Oregon families seeking autism treatment have had challenges getting coverage for ABA in recent years.

"Recent court decisions have made it clear that ABA should be a covered service when it's appropriate for the patient," said Insurance Commissioner Laura Cali. "We expect insurers to stop applying blanket exclusions in their policies and claims practices that effectively deny access to medically necessary treatment for mental health conditions."

For any health condition, insurers can make coverage decisions based on whether the treatment is deemed medically necessary for an individual patient. The bulletins clarify that insurers' policies cannot include categorical exclusions that result in broad denials of mental health treatments. And, specifically, they cannot deny treatment for ABA therapy on the basis that it is experimental or investigational.

Consumers can appeal medical necessity denials to the company - and ultimately through the Insurance Division - via an independent review organization.

The Insurance Division has the authority to issue bulletins to clarify requirements of insurance companies under the Oregon Insurance Code and other state and federal laws. The division developed the bulletins through a public process and received feedback from consumers, advocates, insurers, and other interested parties.

Consumers with outstanding claims should contact their insurance company. They also can call the Insurance Division Consumer Advocacy Unit at 1-888-877-4894 (toll-free) or email cp.ins@state.or.us.

You can find the bulletins and more information on the Insurance Division's website at http://www.oregon.gov/DCBS/insurance/legal/bulletins/Pages/proposed-bulletin-review.aspx.

The Insurance Division is part of the Department of Consumer and Business Services, Oregon's largest business regulatory and consumer protection agency. Visit www.dcbs.oregon.gov and www.insurance.oregon.gov.

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

OREGON INSURANCE DIVISION BULLETIN INS 2014-1

TO: All Health Insurers, Health Care Service Contractors and Other Interested Persons

DATE: November 14, 2014

SUBJECT: Mental Health Parity

I. Introduction

A. Purpose of Bulletin

This bulletin provides guidance to insurers about the expectations of the Oregon Insurance Division (division) for insurers in implementing state and federal mental health mandates. The specific mandates addressed in this bulletin are:

1. ORS 743A.168 (Oregon MHP) and implementing rules at OAR 836-053-1404 and 836-053-1405;

2. The Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act, 29 U.S.C. 1185a (MHPAEA) and implementing regulations at 45 CFR §§146.136 and 147.160; and

3. The federal Affordable Care Act (ACA), its federal regulations, and related Oregon legislation at ORS 731.097 and 743.822 and rules at OAR 836-053-0008 and 836-053-0009.

References to "mandates" in this bulletin include the Oregon Mental Health Parity Statute, ORS 743A.168 (Oregon MHP) and MHPAEA mandates as implemented under the Affordable Care Act. If only one mandate is discussed, the bulletin specifies which mandate.

B. Background

The division has taken into account a number of recent developments in preparing this bulletin. These developments include activities in Oregon and throughout the country:

- Adoption of final MHPAEA regulations, providing clarity on the parity requirements of federal law and the interaction of the federal MHPAEA with state mental health requirements.
- Publication of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), replacing the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" (DSM-IV).

- Changes in coverage required under the Affordable Care Act;
- Court decisions in Oregon under Oregon MHP—including *A.F. v. Providence*, a class action lawsuit—and similar decisions in other states;
- IRO decisions that have repeatedly overturned insurers' denials of coverage for treatment of mental health conditions;
- HERC review and recommendation to cover certain mental health treatments;
- Adoption of a number of bulletins and rules by other states that address mental health parity statutes similar to Oregon MHP. These states include California, Indiana, Washington, and New York.

A list of and citations for many of these developments is included in Appendix A to Bulletin INS 2014-2.

C. Summary

The division expects insurers to comply with the following guidelines:

- An insurer must determine coverage of services and treatment of mental health and chemical dependency conditions in the same manner as the insurer makes a determination of services and treatment for other medical conditions. For any mental health condition, the decision must be based on an individualized determination of medical necessity under the terms of the policy.

- Although an insurer may determine that a treatment is not required to be covered because the treatment falls within a statutory or contract exclusion, the insurer may not categorically deny in all circumstances a treatment that in some circumstances is medically necessary for a mental health condition. An insurer may not apply a categorical exclusion (such as exclusions for developmental, social, or educational therapies) to a class of mental health conditions that results in the denial of medically necessary care or otherwise results in one of the mandates being effectively meaningless.

- Certain specific exclusions from mental health coverage are expressly allowed by the Oregon MHP. Any exclusion must be applied and evaluated on a case by case basis.

- The division will monitor adverse benefit determinations to determine whether an insurer continues to deny treatment on the same basis for which a treatment denial was overturned on appeal, including decisions by an independent review organization (IRO). An insurer should review its appeals and IRO decisions for guidance on handling of future appeals and benefit determinations.

- Insurers should apply a determination of "medically necessary" and "experimental or investigational" to specific treatments covered by the mandates in a manner no more restrictive than applied to substantially all medical and surgical conditions. The definition of medical necessity must comply with all requirements of state and federal law, cannot be so stringent as written or as applied that it renders the mandates meaningless, and must be communicated and applied in a way that allows both the consumer and the division to readily identify in advance the services covered and the procedures necessary to obtain coverage.

- The division will work with individual carriers to address pending complaints related to mental health coverage.

D. Related Bulletins

INS 2014-2 provides more specific guidance for coverage of the treatment of autism spectrum disorders and, specifically, applied behavior analysis therapy.

INS 2013-2 Senate Bill 91 (2011) Standard Plans is withdrawn.

INS 2012-1 addresses discrimination on the basis of gender identity or gender dysphoria. The guidance of INS 2012-1 is supplemented by the provisions of this bulletin to the extent that this bulletin provides additional guidance for the treatment of all mental health conditions including gender dysphoria.

INS 2003-3 is withdrawn and replaced by this bulletin.

II. Discussion

A. History of Provisions

The predecessor of Oregon MHP was first adopted in 1975, and the statute has undergone numerous changes since first enacted. However, the Oregon MHP has not been significantly amended since 2005, when the requirements of the existing mandate were extended to parity coverage of chemical dependency, including alcoholism, and mental or nervous conditions. Thus, the coverage requirement under ORS 743A.168 as it currently exists applies to all group plans issued or renewed after January 1, 2007 (the effective date of last major amendments to ORS MHP).

The Oregon MHP is part of the benchmark plan establishing Oregon's essential health benefits plan under OAR 836-053-0008. Nothing in this bulletin interpreting the Oregon MHP establishes a new benefit under the ACA.

Federal mental health parity was first adopted in 1996, and like Oregon MHP has undergone significant changes since first enacted. However, the federal mental health parity law has not been significantly amended since 2008, when MHPAEA was enacted. The final MHPAEA rule applies to plan years (in the individual market, policy years) beginning on or after July 1, 2014.

The coverage requirements of the Oregon MHP apply to individual policies issued or renewed on or after January 1, 2014 that comply with all 2014 ACA market reforms ("ACA-compliant policies") through the ACA essential health benefits (EHB) requirement. Individual grandfathered and transitional plans are not subject to the Oregon MHP and coverage of the mandates is not required, because these plans are not required to provide essential health benefits. All group plans are subject to the mandates - including ACA-compliant, grandfathered and transitional plans.

Because the state and federal mental health mandates are not new requirements, the division expects insurers to comply with the laws and provide the mandated coverage in accordance with the guidance in this bulletin.

B. Applicable Policy Types:

On its face, the Oregon MHP statute applies only to small and large groups. However, the benchmark plan sets the base requirements that all non-transitional and nongrandfathered individual and small group plans in Oregon must meet to be considered ACA-compliant. Therefore, the Oregon MHP requirement applies to all ACA-compliant individual and small group health benefit plans. For those plans that are not ACA-compliant, i.e., grandfathered or transitional plans, Oregon MHP mandate applies only to small and large group plans.

The MHPAEA applies to all large group health benefit plans that cover mental health benefits. The ACA incorporates the requirements of the MHPAEA and applies them to small group and individual policies. When combined with the requirement that ACA-compliant plans must have mental health and substance abuse coverage based on the Oregon benchmark, MHPAEA applies to all health benefit plans that cover mental health benefits, except grandfathered and transitional small group plans.

Thus, the guidelines of this bulletin apply as follows:

- Oregon MHP by its terms applies to group insurance.
- Federal MHPAEA applies to all plans that cover mental health benefits – individual, small group (except grandfathered and some transitional small group plans) and large group. It requires parity of treatment; i.e., if mental health is covered, it must be treated at parity with other medical conditions.
- ACA-compliant health benefit plans issued or renewed on or after January 1, 2014 must cover mental health because those plans must cover all EHBs including mental health coverage.
- Oregon's benchmark plan includes mental health coverage because the PacificSource small group plan was governed by the Oregon MHP statute. Oregon's benchmark plan applies to all ACA-compliant plans after January 1, 2014. This includes individual and small group plans both in and out of Cover Oregon.

C. Coverage Requirements

Under State Law:

ORS 743A.168 sets forth the requirements for treatment of "mental or nervous conditions." That statute states in part:

> A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

The division defined "mental or nervous conditions" by rule to mean all disorders listed in the "Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition" except for enumerated diagnostic codes that are exceptions. The excepted codes include codes related to mental retardation, learning disorders, paraphilias and some relationship-related codes, OAR 836-053-1404(1)(a). This rule was inclusive in that it identified all conditions in DSM-IV-TR as

subject to the Oregon MHP mandate, with three narrow and specific exceptions – certain diagnostic codes related to mental retardation, learning disorders and paraphilias, and some "V" codes for children older than five years. With these exceptions, every diagnosis in DSM-IV-TR is a mental health or nervous condition and subject to Oregon MHP and this bulletin.

In connection with this bulletin, the division is adopting a temporary rule to update the references in OAR 836-053-1404(1)(a) to include the parallel references in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Under this rule either DSM-IV or DSM 5 is referenced to define mental or nervous conditions, depending on which edition of the Manual provided the criteria for diagnosis. For diagnoses made before the effective date of the rule using DSM-5, the insurer should evaluate whether the diagnosis is a "mental or nervous condition" using a standard crosswalk between DSM-5 diagnostic codes and DSM-IV-TR diagnostic codes.

Applying this definition to the Oregon MHP mandate, any disorder included in the DSM-IV-TR or DSM -5 diagnostic codes, as applicable, apart from the specific exclusions, is subject to the mandate. For example, depression, anxiety, autism and gender dysphoria are subject to the mandate. If a mental or nervous condition is encompassed by the mandate, an insurer must provide coverage for medically necessary treatments for the condition. Recent judicial opinions have indicated that if a plan excludes a therapy regardless of whether it is medically necessary, the blanket exclusion violates the mental health parity requirements if the therapy may be medically necessary to treat a mental disorder,

Under Federal Law:

MHPAEA is not a mandate to require coverage, but rather it is a requirement that when mental health coverage is included in a health plan or policy, the coverage must be in parity with coverage of all other medical conditions. The federal mandate arises from applying the parity requirement of MHPAEA to policies that have mental health coverage, including but not limited to coverage mandated by ORS 743A.168 or the ACA. Thus, all ACA-compliant individual policies and all group policies must provide mental health coverage that is in parity (using MHPAEA tests) with the medical benefits provided by the policy or plan. Also, any transitional or grandfathered plans that provide mental health coverage must apply the MHPAEA tests to assure parity.

Final regulations implementing MHPAEA were published in the Federal Register on November 13, 2013.[1] This bulletin provides a high-level summary of the MHPAEA regulations, but insurers are responsible for implementing the regulations in detail, whether or not summarized here.

Under these regulations, an insurer may not apply any financial requirement or quantitative treatment limits to mental health benefits *in any classification* that is more restrictive than the *predominant* financial requirement or quantitative treatment limitation of that type applied to *substantially all* medical benefits in the same *classification*. As specified in the regulations, the six classifications of benefits to be used are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

[1] 45 CFR 146.136 and 147.160.

The "substantially all" and "predominant" tests are determined separately for each type of financial requirement or quantitative treatment limitation. A type of financial requirement or quantitative treatment limitation is considered to apply to *substantially all* medical benefits in a classification of benefits if it applies to at least 2/3 of all medical benefits in that classification. If a financial requirement or quantitative treatment limitation *does not apply* to at least 2/3 of all medical benefits in a classification, then the financial requirement or quantitative treatment limitation of that type *cannot be applied* to mental health benefits in that classification.

In evaluating a quantitative treatment limitation, the comparison is always between a mental health benefit and substantially all medical or surgical benefits in that classification, not to only one medical or surgical benefit, even if that medical surgical benefit is analogous to the mental health benefit in question. If a type of financial requirement or quantitative treatment limitation applies to at least 2/3 of all medical benefits in a classification, the predominant level is the level that applies to more than ½ of the medical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

A plan may not impose a non-quantitative treatment limit (NQTL) on mental health benefits unless the processes, strategies, and evidentiary standards used in applying the NQTL to mental health or substance abuse benefits in the classification are comparable to, and are applied no more stringently than those used in applying the NQTLs to medical benefits in the same classification.

Examples of NQTLs include the following:

- Medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective;
- Exclusions based on failure to complete a course of treatment; and
- Coverage restrictions based on geographical location, facility type and provider specialty, and other criteria that limit the scope or duration of benefits for services.

Oregon MHP has both a mandate for coverage and a parity requirement, while MHPAEA has only a parity requirement. The division considers any health benefit plan that complies with the MHPAEA regulations to have satisfied the parity requirements of Oregon MHP.

D. Exclusions or Limitations

ORS 743A.168 specifies the permitted exemptions and treatment limitations related to the mandate.

- The deductibles and coinsurance for other medical conditions apply to mental health conditions, but under no circumstances may deductibles or coinsurance for mental health conditions exceed those for other medical conditions:

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

- Treatment limitations are allowed only if similar to those imposed on other medical conditions:

  (3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

- ORS 743A.168(4)(a) expressly allows exclusions for:

  (A) Educational or correctional services or sheltered living provided by a school or halfway house;
  (B) A long-term residential mental health program that lasts longer than 45 days;
  (C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or
  (D) A court-ordered sex offender treatment program.

Although these limitations or exclusions are allowed under state law, insurers must be mindful of the restrictions on these exclusions or limitations under the MHPAEA or other mandates. In some instances, such as the 45-day standard for long-term residential mental health programs in ORS 743A.168(4)(a)(B), the limitation can be saved if interpreted as a floor rather than as a maximum number of treatments the insurer must cover. If applied as a limitation, it must be analyzed as required by MHPAEA. If a categorical limitation or exclusion effectively denies all coverage for a treatment for a mental health condition, the limitation or exclusion would not be permitted because no similar exclusion bars coverage for the treatment of any other medical condition. In other instances, the insurer must examine a quantitative limitation in light of the recently adopted federal MHPAEA rules. For example the 45 day standard for long-term residential mental health programs in 743A.168(4)(a) is a quantitative treatment limitation prohibited by MHPAEA unless substantially all medical treatments in the same classification are subject to the same or more restrictive limitations. Similarly, the 30-visit limits for speech therapy, occupational therapy and physical therapy in Oregon's Essential Health Benefits package are quantitative treatment limitations prohibited by MHPAEA when the therapy is to treat a mental health condition.

In addition to the requirements of Oregon's MHP and the federal MHPAEA , 45 CFR 156.125(a) provides that a health benefit plan fails to provide essential health benefits "if its benefit design, or *the implementation of its benefit design*, discriminates based on . . . present or predicted disability, degree of medical dependency, quality of life, or other health conditions." (Emphasis added.) 45 CFR 146.121 (which applies to individual health benefit plans pursuant to

45 CFR 147.110) prohibits an insurer from discriminating against an insured based on health factors. Health factors include health status, medical condition, and medical history. 45 CFR 146.121(a). Thus, the implementation of a health plan's mental health benefit design may not discriminate on the basis of mental health status, mental health condition, or mental health history.

45 CFR 156.110 states that a health benefit plan that includes a discriminatory benefit design in contravention of the standards described in 45 CFR 156.125 does not comply with the essential health benefits requirements of the Affordable Care Act. Accordingly, a health benefit plan that employs such a benefit design with respect to an essential health benefit like mental health treatment fails to provide essential health benefits.

An insurer may not require a special rider or endorsement or impose an additional premium for an insured to obtain mental health coverage. This would violate Oregon MHP and in most instances would violate MHPAEA as well. 45 CFR 156.110.[2]

Some policies include broad-based treatment exclusions that are based on categories such as "academic or social skills training," "educational," or "sexual dysfunction." Recent judicial opinions, however, have disallowed such broad exclusions, where they undercut mandates. If the exclusion operates to nullify a mandate, the exclusion is too broad and must be restricted. In other words, an insurer may not profess to include coverage required by the state and federal mental health mandates while at the same time applying a broad exclusion in a way that prevents the insured from receiving medically necessary treatment.

While ORS 743A.168 (4)(a), quoted above, specifically excludes "[e]ducational or correctional services or sheltered living provided by a school or halfway house" and "[p]sychoanalysis or psychotherapy received as part of an educational or training program," a carrier may not exclude all medically necessary treatment for a mental or nervous disorder by classifying the treatment as "educational or correctional" rather than medical. The exclusions allowed are limited to specific circumstances (e.g., "provided by a school or halfway house" and "received as part of an educational or training program"). To expand the exemption by categorizing an entire form of treatment as "educational" regardless of where or how it is provided exceeds the scope of the statutory exemption.

E. Individualized Determinations

Medical Management:

ORS 743A.168 (8) and (9) allow and encourage the application of medical management and utilization review techniques for mental health coverage. Similarly, 45 CFR 156.125(c) allows a health benefit plan to use reasonable medical management techniques in the provision of

[2] Even if a benefit restriction applies uniformly to all similarly situated individuals, it must still satisfy the requirements of the ACA provisions relating to essential health benefits, including 42 U.S.C. 18022, 45 CFR 146.115, 146.12, and 146.125. 45 CFR 156.115.

essential health benefits,[3] and 45 CFR §146.136(c)(4) applies the same provision to mental health benefits specifically.

Independent Review Organizations:

Insureds may employ an IRO to review adverse decisions regarding medical necessity or experimental exclusion and similar matters of medical judgment. ORS 743.857 to 743.864 and OAR 836-053-1300 to 836-053-1365. The division reviews the results of IRO decisions including those decisions regarding mental health treatments. When an IRO finds that a treatment is medically necessary, the division will look at an insurer's subsequent denials to determine whether the insurer is continuing to deny the same treatment on the same basis. The insurer should be prepared to explain how the denial differs from the company's previous denials overturned by external review. Although IRO determinations are not binding beyond the individual case and are not available to other insurers, the division considers patterns of IRO decisions significant evidence in determining whether to examine more closely any pattern of denials related to a mental health treatment.

Guidelines and Transparency:

The following guidelines refer to mental health coverage but are not exclusive to mental health coverage provisions:

- Insurers should review definitions of "medically necessary" and "experimental or investigational" that are applied to treatments covered by the mental health mandates. These definitions must comply with other requirements and may not apply more stringent requirements to mental health treatments in violation of ORS 743A.168 and MHPAEA.
- An insurer must not avoid the appeals process by simply "providing information" to an insured verbally that a particular treatment is not covered. The insured should be encouraged to submit the proposed treatment (in the form of a prior authorization request if appropriate) so that the insurer can consider the medical necessity of the treatment and respond in writing with a coverage decision. A denial must include information about the appeal process and opportunity for external review and conform to state and federal statutory and regulatory requirements.
- In handling mental health conditions and their treatment, insurers should be very clear about what the policy or plan covers, and include notices and disclaimers consistent with state and federal law and requirements (e.g., ERISA notice requirements).
- In evaluating medical necessity for any treatment requested for a mental health condition, the insurer must evaluate the request using general standards but also when possible with peer-reviewed scientific studies of clinical effectiveness and with specialty standards established by national or international medical, clinical or research organizations that have studied or specialize in treatment for a particular condition.
- For common or recurrent conditions, insurers should adopt and use medical necessity guidelines that it makes available to providers and insureds. When coverage is denied, the

---

[3] *See* Question 1 FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, December 22, 2010, United States Department of Labor. Available here: http://www.dol.gov/ebsa/faqs/faq-aca5.html. Reasonable medical management techniques are primarily designed to allow insurers to control costs and steer patients toward high value, efficient medical treatment.

insurer should refer to the guideline in making an individualized determination of medical necessity. This is not to say that every case will be decided by the logic of a guideline, only that the framework for decision must be transparent to the provider and insured.

- Insurers should issue internal memos, train staff, and provide documentation to staff and providers clarifying the services provided for specific mental health conditions, the requirements for demonstrating medical necessity for these conditions and the process an insured must follow to appeal a denial.

III. Enforcement

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.

This bulletin is dated the 14th of November, 2014, at Salem, Oregon.

Laura N. Cali, FCAS, MAAA
Insurance Commissioner

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

OREGON INSURANCE DIVISION BULLETIN INS 2014-2

TO: All Health Insurers, Health Care Service Contractors and Other Interested Persons

DATE: November 14, 2014

SUBJECT: Autism Spectrum Disorder; Applied Behavior Analysis Therapy

I. Introduction

A. Purpose of Bulletin

Today, the Oregon Insurance Division (division) issued bulletin INS 2014-1 detailing the division's expectations of insurers issuing coverage subject to state and federal mental health mandates. This companion bulletin INS 2014-2 provides additional guidance to insurers about the expectations of the division regarding health benefit plan coverage for autism spectrum disorder (ASD) and other pervasive developmental disorders (PDDs), including the treatment known as applied behavior analysis (ABA).

In addition to the laws described in bulletin INS 2014-1, the specific statutes related to ASD, PDD, and ABA are:

1. ORS 743A.190 (Oregon PDD); and
2. Enrolled Senate Bill 365 (2013 Legislative Session), 2013 Oregon Laws Chapter 771 (SB 365). In addition to adding provisions to the Insurance Code, SB 365 enacted ORS 676.800, creating the Behavior Analysis Regulatory Board (BARB).

In this bulletin, ABA has the meaning defined in SB 365. References to "mandates" in this bulletin include the Oregon Mental Health Parity (MHP), Oregon PDD, and the federal Mental Health Parity and Addition Equity Act (MHPAEA) as implemented under the Affordable Care Act (ACA). If only one mandate is discussed, the bulletin specifies which mandate.

B. Background

In 2013, the division began developing guidance to clarify whether Oregon's Essential Health Benefit (EHB) Benchmark plan, the PacificSource Codeduct Value plan,[1] included coverage of

[1] OAR 836-053-0008(1)(a).

ABA. After considering the current status of pending lawsuits, work group discussions before and during the 2013 Legislative Session, and legislative history related to SB 365, the division decided to postpone issuing this guidance until the U.S. District Court for the District of Oregon adjudicated the legal arguments in the *A.F. v. Providence* lawsuit.
In August, 2014, the U.S. District Court for the District of Oregon issued its opinion on the legal arguments in *A.F. v. Providence*, a class action lawsuit challenging denial of coverage for ABA therapy in Oregon. A number of other developments also have occurred that are consistent with that opinion and that have assisted the division in developing this bulletin:

- Court decisions in Oregon and in other states with laws similar to ORS MHP and Oregon PDD;
- Independent Review Organization (IRO) decisions that have repeatedly overturned insurers' denials of coverage for ABA;
- Health Evidence Review Commission (HERC) review and recommendation to cover ABA therapy;
- Bulletins and rules adopted by insurance regulators in other states that address ABA issues and statutes similar to Oregon's statutes. These states include California, Indiana, Washington, and New York.

A list of and citations for many of these developments is attached in Appendix A to this bulletin.

C. Summary

The division expects insurers to comply with the following guidelines:

- An insurer must adjudicate ASD and PDD claims as mental health claims subject to state and federal mental health parity laws.

- An insurer may not categorically deny treatment for ABA therapy on the basis that the treatment is experimental or investigational. Coverage decisions must be made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. Such determinations must meet the requirements of federal and state law, including mental health parity standards as set forth in INS 2014-1 and OAR 836-053-1405.

- 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 being effectively meaningless for ASD or PDDs.

- ABA therapy is a medical service for purposes of ORS 743A.190.

- Under SB 365, a provider actively practicing applied behavior analysis on August 14, 2013 (a "grandfathered provider") may claim reimbursement from a health benefit plan without being licensed until January 1, 2016. A grandfathered provider has that status for any insurer and for any patient. An insurer may impose credentialing requirement on ABA providers so long as the credentialing requirements do not prevent access to treatment required under the mandates. An insurer is not required to contract with any willing provider, but the insurer may not discriminate against any category of

legislatively authorized provider of ABA services and may not negate the mandate to cover medically necessary mental health services by refusing to credential legally qualified providers.

- The provisions of SB 365 that establish quantitative standards—the 25-hour per week coverage standard and the nine-year old age standard—are floors, not limitations on ABA coverage. As floors these provisions do not violate the MHPAEA. If applied as limits, these provisions would violate MHPAEA and its regulations, unless the insurer imposed the same limits as the predominant treatment limitation on substantially all of its medical or surgical outpatient coverage.

D. Related Bulletins

INS 2014-1 related to mental health parity provides general guidelines for all mental and nervous conditions. Because ASD and PDD are mental health conditions subject to all of the mental health laws described in bulletin INS 2014-1, all of the discussion in bulletin INS 2014-1 applies to ASD and PDD. This bulletin describes additional considerations specific to ASD, other PDDs, and ABA.

II. Discussion

A. Applicability

The Oregon PDD statute applies to health benefit plans issued or renewed on or after January 1, 2008. This statute was incorporated by law into the policy selected by Oregon as its benchmark plan establishing Oregon's essential health benefits (EHB) plan under OAR 836-053-0008. The benchmark plan, with limited exceptions, establishes the baseline requirements for all individual and small group health benefit plans to be considered ACA-compliant (i.e., comply with all 2014 reforms, including but not limited to essential health benefits, nondiscrimination and guaranteed issue).

SB 365 requires health benefit plans to cover screening, diagnosis, and medically necessary treatment for ASD, including ABA therapy. It applies to commercial health benefit plans that are issued or renewed on or after January 1, 2016. It also applies to the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) for coverage beginning on or after January 1, 2015; both boards have decided to accelerate the effective date of ABA coverage (PEBB to August 1, 2015, OEBB to October 1, 2015).

B. Coverage Requirements

Under State Law:

The Oregon PDD statute 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."

SB 365 defines ASD using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As bulletin INS 2014-1 mentions, the division is adopting a rule to update the references in OAR 836-053-1404(1)(a) to include the parallel references in DSM-5. ASD as defined in SB 365 is a PDD under ORS 743A.190 and a "mental or nervous disorder" under Oregon MHP.

The provisions of SB 365 that apply beginning January 1, 2016 (a year earlier for PEBB and OEBB) are those specifically concerning procedures for management of ABA therapy. The general requirement to cover medically necessary treatment for ASD already exists in the Oregon MHP and Oregon PDD. Insurers should provide access to ABA under existing law (Oregon MHP and PDD) as they would for any other treatment for a mental health condition.

Under Federal Law:

As bulletin 2014-1 summarizes, the regulations under MHPAEA prohibit quantitative treatment limits on mental health benefits in any classification (e.g. inpatient, outpatient) that are more restrictive than the predominant quantitative treatment limitation of that type applied to substantially all medical benefits in the same classification. Because of this requirement, the 25-hour per week floor for coverage of ABA therapy and the requirement to provide coverage if an individual begins treatment before nine years of age established in SB 365, if applied as limitations, could violate MHPAEA and therefore be prohibited. As stated in the preamble to the final MHPAEA rules, the parity requirements of MHPAEA may require an insurer to provide mental health benefits beyond the state minimum.[2]

C. Exclusions or Limitations

An insurer may apply age limits to coverage of ABA therapy only in a way consistent with the mandates. While medical necessity guidelines are helpful, the medical necessity and experimental character of the treatment must be considered on an individualized basis for a person of any age.

Insurers typically issue policies with broad-based treatment exclusions. Recent opinions by courts, however, have indicated that although insurers may limit their coverage by including broad exclusions, the scope of the exclusion must be restricted if the exclusion is inconsistent with a statutory mandate. An insurer may not profess to include ASD and PDD coverage required by these mandates while at the same time applying a broad exclusion that prevents the insured from receiving medically necessary treatments for these conditions.

D. Provider Qualifications

ORS 676.800 establishes the Behavior Analysis Regulatory Board (BARB) and sets out the requirements for licensing and registering professionals who provide treatment for ASD using ABA. Although SB 365 prohibits a provider who has not been licensed or registered by the BARB from seeking reimbursement from an insurer starting in 2016, the bill recognizes the need to allow continued services until the licensing and registration procedures are in place. As a result, SB 365 grandfathers certain providers who were actively practicing ABA therapy on the

[2] 78 Federal Register at 68252.

effective date of the Act (August 14, 2013) and allows these providers to continue to claim reimbursement without registration or licensing.

Grandfathering applies if the individual was actively practicing ABA on August 14, 2013, whether as a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCABA), a licensed health care provider, or an interventionist (paraprofessional). For purposes of grandfathering, it is not required that the individual was being reimbursed by an insurer on August 14, 2013, so long as he or she was actively practicing ABA at that time. The division expects insurers to provide reimbursement to grandfathered ABA providers until expiration of the grandfathering period on January 1, 2016. This is consistent with the intent of SB 365 to make resources available for access to ABA that insureds might not have if limited to BARB-licensed or certified providers.

At this time, BARB expects the ABA licensing process to be available on December 1, 2014. After the licensing process is available, a new provider who was not actively practicing on the effective date of SB 365 must be licensed or registered in order to be reimbursed by an insurer.

Because the BARB is within the Oregon Health Authority's Health Licensing Office, providers who have been registered with or licensed by the BARB are considered to be "approved" by the Oregon Health Authority for the purposes of ORS 743A.168(5)(a) and thus eligible for reimbursement under Oregon MHP. Under the provider nondiscrimination provision in ACA Section 2706(a), 42 U.S.C. § 300gg–5, insurers may not discriminate in ACA compliant plans against ABA providers licensed by or registered with BARB. Because the grandfathering provision is an applicable state law in lieu of licensure or certification, Section 2706(a) also applies to grandfathered providers in ACA compliant plans.

An insurer may apply credentialing requirements to grandfathered providers so long as the credentialing requirements do not prevent access to medically necessary treatment as mandated by state and federal law. The division does not interpret SB 365 to require an actively practicing ABA provider to seek reimbursement from the same insurer or for the same patient in order to qualify under the grandfather provision.

E. Independent Review Organizations

The division has identified 22 instances since 2008 in which insurers' denials of ABA therapy were overturned by an IRO. The insurers' denials were based on determinations that the treatment was experimental or investigational. In these instances, the determinations were overturned by the IRO, which found that such treatment is the recognized standard of care for autism.

Insurers may not deny ABA claims as experimental or investigational unless there is a basis for determining that for a specific patient. The division will examine IRO decisions regarding ASD treatments including ABA therapy to determine if insurers are denying ABA claims on grounds not permitted by law.

III. Enforcement

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.

This bulletin is dated the 14th of November, 2014, at Salem, Oregon.

Laura N. Cali, FCAS, MAAA
Insurance Commissioner

Appendix A

AUTHORITIES

A. Legislative and Regulatory Materials

1. Cal. Health and Safety Code, 1374.72
2. California Code of Regulations, Subchapter 3 of Chapter 5 of Title 10, Article 15.2: Mental Health Parity, Sections 2562.1 to 2562.4
3. California Department of Insurance, Notice "Enforcement of Independent Medical Review Statutes" (May 17, 2011).
4. CMCS Informational Bulletin, "Clarification of Medicaid Coverage of Services to Children with Autism" dated July 7, 2014.
5. DCBS 2009 Review of Coverage of Mental or Nervous Conditions and Chemical Dependency in Accordance with OAR 836-053-1405(8)
6. Health Evidence Review Commission (HERC) coverage determination for ABA for ASD (8/14/14)
7. HERC coverage determination for surgical sexual transition for gender dysphoria (8/14/14)
8. In Re United Health Care Insurance Company, Stipulation and Waiver (California Insurance Commissioner Order)
9. Indiana Bulletin 136 (March 30, 2006)
10. MHPAEA final rules, Federal Register Vol. 78, No. 219 p. 68240 (November 13, 2013); 45 CFR §§ 146.136 and 147.160
11. New York Articles on Requirements for MHP
12. Senate Bill 365 Legislative History
13. Washington Insurance Commission, Letter dated October 20, 2014

B. Court Cases

1. Arce v. Kaiser Foundation Health Plan, 181 Cal App 4th 471 (2010) Settlement Agreement and Order Approving Settlement
2. AF ex rel Legaard v. Providence Health Plan, 2014 WL 3893027 (2014)
3. AG et al. v. Premera Blue Cross and Lifewise, No. 11-2-30233-4SEA, J.P. v. Premera Blue Cross, No. 12-2-33676-8SEA, and R.H. v. Premera Blue Cross and Lifewise, No. 2:13-cv-00097-RAJ, Proposed Settlement Agreement (May 7, 2014).
4. Berge v. US, 879 F Supp 2d 98 (D.D.C., 2012) and 949 F Supp 2d 36 (D.D.C., 2013)
5. Boyle v. Blue Cross Blue Shield of N.C., 2011 WL 60000786 (E.D. Mich., 2011)
6. Chisholm ex rel CC, MC v. Kilebert, 2013 WL 3807990 (E.D.La., 2013)
7. Churchill v. Cigna Corp., 2012 WL 3590691 (E.D.Pa., 2012) and Stipulation of Settlement (January 2014)
8. DF et al v. Washington State Health Care Authority et al, Superior Court of Washington for King County, Case no. 10-2-29400-7 (June 8, 2011)
9. Hummel v. Ohio Dept. of Job and Family Services, 164 Ohio App 3d 776, 844 NE 2d 360 (2005)
10. Johns v. Blue Cross Blue Shield of Michigan, Case No. 2:08-cv-12272 (E.D. Mich) Proposed Settlement and Order Approving Proposed Settlement.
11. KG ex rel Garrido v. Dudek, 864 F Supp 2d 1314 (S.D.Fla., 2012) aff'd in part, 731 F3d 1152 (11th Cir., 2013)

12. KM v. Regence Blueshield, 2014 WL 801204 (W.D.Wa., 2014), and Settlement Agreement (October 2014)
13. Markiewicz v. State Health Benefits Commission, 390 N.J. Super 289, 915 A2d 553 (2007)
14. Mayfield v. ASC Inc. Health & Welfare Benefit Plan, 2007 WL 5272861 (E.D.Mich., 2007)
15. McHenry v. PacificSource, 679 F Supp 2d 1226 (D.Or., 2010)
16. Micheletti v. State Health Benefits Commission, 389 N. J. Super 510, 913 A2d 842 (2007)
17. O.S.T .v. Regence Blueshield, 88940-6, 2014 WL 5088260 (Wa. October 9, 2014)
18. Parents' League for Effective Autism Services v. Jones-Kelley, 339 F. Supp. 2d 542 (6th Cir., 2009)
19. Potter v. Blue Cross Blue Shield of Michigan, 2013 WL 4413310 (E.D. Mich).
20. Reid v. BCBSM, Inc., 984 F Supp 2d 949 (D., Minn., 2013)
21. SAH ex rel SJH v. State Dept. of Social and Health Services, 136 Wash App 342, 149 P3d 410 (2006)
22. ZD v. Group Health Cooperative, Case 2:11-cv-01119-RSL, Settlement Agreement filed 8/2/13 (United States District Court, Western District of Washington)

C. Arbitration Awards

1. Tappert v. Anthem Blue Cross Blue Shield, JAG Case No. 270779 (Nov. 20, 2007)

D. Articles

1. Daniela Caruso, Autism in the U.S.: Social Movement and Legal Change, 36 Am. J. L. & Med. 483 (2010)
2. Jeffrey A. Cohen, Thomas A. Dickerson, Joanne Matthews Forbes, A Legal Review of Autism, A Syndrome Rapidly Gaining Wide Attention in Our Society, 77 Alb. L. Rev. 389 (2014)
3. Kendra Hansel, Rethinking Insurance Coverage of "Experimental" Applied Behavioral Analysis Therapy and Its Usefulness in Combating Autism Spectrum Disorder, 34 J Legal Med 215 (2013)
4. Laura C. Hoffman, Ensuring Access to Health Care for the Autistic Child: More Is Needed Than Health Care Reform, 41 SW L. Rev. 435 (2012)
. Laura C. Hoffman, Health Care for the Autistic Child in the U.S.: The Case for Federal Legislative Reform for ABA Therapy, 46 J. Marshall L. Rev. 169 (2012)

ELLEN F. ROSENBLUM
Attorney General

FREDERICK M. BOSS
Deputy Attorney General

DEPARTMENT OF JUSTICE
GENERAL COUNSEL DIVISION

For Public Release

November 14, 2014

Laura Cali, Commissioner
Oregon Insurance Division, DCBS
350 Winter Street NE
Salem, OR 97309-0405

Re: Statutory Questions Related to Applied Behavior Analysis (ABA) and Mental Health Parity Bulletins

Dear Laura,

Questions of statutory interpretation have arisen in your drafting of bulletins 2014-1 (Mental Health Parity or MHP) and 2014-2 (ABA Therapy). Here we answer these questions.

Questions and Short Answers

1. *What does the provision grandfathering ABA providers mean?* A provider who was actively practicing ABA on August 13, 2013, may claim reimbursement from a health benefit plan, without being licensed. Such a provider may be considered grandfathered by any insurer for any patient. An insurer may impose credentialing requirements on ABA providers and is not required to contract with any willing provider, but the insurer may not discriminate against all practitioners of ABA and should ensure access to ABA.

2. Do Oregon's quantitative statutory coverage minimums violate federal mental health parity? No. These provisions are floors, not limitations on coverage. To achieve parity, however, an insurer that follows quantitative standards like these for ABA coverage must impose the same predominant limitation to at least two-thirds of medical and surgical benefits of the same classification.

3. Is ABA a "medical service" required by the pervasive developmental disabilities (PDD) mandate? Yes.

4. In providing ABA services, may an insurer impose exclusions such as those listed in the MHP and ABA mandates? Yes. Categorical limitations and exclusions are permitted, subject to parity requirements. However, categorical limitations and exclusions must be interpreted so as not to effectively deny all coverage for ABA.

5. May an insurer apply to ABA the managed care provisions of the Oregon MHP and PDD statutes, such as credentialing, cost sharing, treatment limitations, utilization review,

and network contracting? Yes. Again, these provisions must be applied in a way that does not effectively deny all coverage for ABA.

6. May an insurer use the parameters of 2013 SB 365 before its effective date as a framework for benefit administration in order to comply with the bulletins? Yes.

7. To what extent may the Division rely on A. F. v. Providence, even though that is a District Court opinion still subject to appeal? OID should examine the implications of all available case law, particularly cases applying or decided under Oregon law (to date, *A. F. v. Providence* and *McHenry v. PacificSource)*. Where the highest court with jurisdiction—the Oregon Supreme Court for Oregon law, the US Supreme Court for federal law—has not ruled on a legal issue, OID has authority to make regulatory judgments, taking into account DOJ advice where the law is uncertain.

8. May the Division reasonably make the bulletins effective August 8, 2014? Yes. The bulletins interpret laws already in effect on that date and thus do not impair obligations of contract. The *A. F. v. Providence* decision marked the date on which OID achieved sufficiently clarity on the interpretation of Oregon statutes to support the position taken in the bulletins.

Applicable Statutes and Regulations

The questions in this letter relate to:

- 2013 SB SB 365, Oregon Laws 2013 chapter 771 (2013) ("SB 365"), which enacts insurance coverage requirements for ABA treatment for autism spectrum disorder (ASD);[1]
- ORS 743A.190, regarding mandatory coverage for minors with a PDD;
- ORS 743A.168, Oregon's MHP statute and its implementing rules at OAR 836-053-1404 and 836-053-1405;[2] and
- 29 USC 1185a, the federal MHP law called the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and its implementing rules at 45 CFR §§146.136 and 147.160.

Discussion

1. What does the provision grandfathering ABA providers mean?

SB 365 established the Behavior Analysis Regulatory Board (BARB) and enacted ORS 676.800(16), which requires a provider to be licensed or registered by BARB as a condition for health benefit plan reimbursement of ABA services:

> An individual who has not been licensed or registered by the Behavior Analysis Regulatory Board in accordance with criteria and standards adopted under this section

[1] The provider certification and licensure provisions of SB 365 are in ORS 676.800 to 676.805. The Insurance Code provisions are reprinted following 743A.250.

[2] OID has published temporary amendments to OAR 836-053-1404 contemporaneously with the bulletins.

> may not claim reimbursement for services described in [SB 365 section 2], under a health benefit plan or under a self-insured health plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

Certain providers, however, were grandfathered out of the license or registration requirement until January 1, 2016. Section 4 of SB 365 states:

> Notwithstanding [ORS 676.800(16)], an individual actively practicing applied behavior analysis on [August 14, 2013] may continue to claim reimbursement from a health benefit plan, the Public Employees' Benefit Board or the Oregon Educators [Benefit] Board for services provided without a license before January 1, 2016.

The text of section 4 has some notable points. First, individuals must be "actively practicing" ABA on August 14, 2013–the effective date of the bill—to fall under the provision. Second, an individual who is actively practicing "may continue to claim reimbursement" for services rendered after the effective date. Third, the provision applies to three different types of payors: a health benefit plan, the Public Employees' Benefit Board (PEBB), and the Oregon Educators Benefit Board (OEBB). Fourth, the claim for reimbursement may be made without the provider meeting license requirements as long as the services are provided before 2016.[3] Read as a whole, the provision suggests a legislative intent to assure access to ABA until newly enacted licensing requirements provide a supply of licensed or registered providers and to allow existing providers time to become licensed or registered.

A. Who is grandfathered?

SB 365 provides that, to meet the definition of ABA, services must be provided by a "licensed health care professional *registered* under section 3," a "behavioral analyst or an assistant behavioral analyst *licensed* under section 3," or a "behavior analysis interventionist *registered* under section 3."[4] ORS 676.800(8)-(11) also distinguishes between the licensing of behavioral analysts and assistant behaviorau analysts, and the registration of licensed health care professionals and behavior analysis interventionists. BARB's final rules (effective December 1, 2014) maintain that distinction, although the rules describe either a license or registration as an "authorization."[5]

ORS 676.800(16), quoted above, requires an individual to be "licensed or registered" by BARB in order to claim insurance reimbursement. The grandfather provision states, however, that those actively practicing ABA may "continue to claim reimbursement *** without a license" notwithstanding ORS 676.800(16), omitting to mention the registration option. The apparent

---

[3] The grandfathering expires on January 1, 2016, the same date on which the mandate of SB 365 § 2 becomes applicable to health benefit plans.

[4] SB 365 defines ABA, in part, as services provided by one of three kinds of providers: licensed health care professionals who are registered under the act, behavioral and assistant behavioral analysts licensed under the act, and behavior analyst interventionists registered under the act. SB 365 § 2(1)(a)(A)(i)-(iii) (emphasis added). The grandfather provision implicitly adds a fourth category to that list: individuals actively practicing ABA on August 14, 2013.

[5] OAR 824-010-0005(4). Pending publication by the Secretary of State in OAR chapter 824, BARB's rules are available at http://www.oregon.gov/OHLA/BARB/docs/BARBrulesFINAL.pdf.

explanation is that insurers already provide health care services through licensed health practitioners; only the unlicensed ones need grandfathering. Once BARB registration goes into effect, licensed health care professionals will have to register with BARB in order to be qualified to provide ABA. Right now, practitioners with existing kinds of licenses—e.g. medical doctors, psychologists, professional counselors, or marriage and family therapists—do not need statutory grandfathering because they do not "claim reimbursement *** without a license." BARB registration obviously was unavailable right after SB 365 became effective, since BARB itself and the ABA practitioner registration procedures were created by SB 365. Nor, over a year later, can a licensed health care professional be registered under BARB. BARB's rules will not be effective until December 1, 2014; and since all BARB licensure and registration actions most be taken by the Board itself, the earliest possible opportunity for BARB licensure and registration is the Board's meeting January 8, 2015. Given the intent we found in Section 4 to assure access to ABA until newly enacted licensing requirements provide a supply of licensed or registered providers and to allow existing providers time to become licensed or registered, we interpret the statute to allow licensed health care providers to be reimbursed for ABA services without BARB registration until such time as BARB determines registration is necessary.

B. What credentialing procedures may insurers require of grandfathered providers?

Section 4 grandfathers individuals who are "actively practicing" ABA on the effective date of SB 365. The bill does not define this phrase, nor has OID or BARB done so. This leaves it to insurers to determine which practitioners have been "actively practicing" ABA.

Oregon's MHP statute applies only to providers that have met the insurer's credentialing requirements.[6] Nothing in SB 365 exempts ABA providers from the credentialing procedures insurers use for providers. As to grandfathered providers, the insurer's credentialing procedures would need to collect information from the provider evidencing, among other things, active provision of ABA on August 14, 2013. Such evidence of active provision could consist of, for example, documentation of providing ABA before and after that date. Insurers may have other credentialing requirements for ABA practitioners, e.g. professional liability insurance. The bill does not create an "any willing provider" provision that requires every insurer to contract with every willing ABA provider.[7] Still, the grandfathering provision makes resources available for access to ABA that the insurers would not have if they limit ABA to licensed providers.

Public Health Service Act section 2706(a), as added by the Affordable Care Act (ACA), states that a "group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law." Section 2706(a) does not require "that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer." For the present purpose, BARB-registered ABA

[6] ORS 743A.168(1)(e)(A), ORS 743A.168(16).

[7] ORS 743A.168(12)(a) provides "A group health insurer is not required to contract with all providers that are eligible for reimbursement under this section."

providers obviously have a "certification under applicable state law" that makes Section 2706(a) apply to them. Since the grandfathering is an applicable state law in lieu of licensure, we believe Section 2706(a) applies to grandfathered providers as well. In short, the ACA prohibits discriminating against ABA providers of any kind authorized by SB 365, including grandfathered ones.

C. What does "continue to claim" reimbursement mean?

As noted, grandfathering allows an unlicensed but active practitioner of ABA to "continue to claim reimbursement." When this phrase is read in the context of the whole provision, it means that an individual who was actively providing ABA services on SB 365's effective date may claim reimbursement through 2015 without obtaining a license.

Under the grandfather provision, actively practicing ABA practitioners may seek reimbursement from any insurer, not just the one(s) who insured a patient they treated on or before the effective date. This interpretation is supported by the use of the word "a" instead of "the" when indicating from whom providers could seek reimbursement: "*a* health benefit plan, the Public Employees' Benefit Board or the Oregon Educators [Benefit] Board." SB 365 § 4. Similarly, no words of limitation suggest that a provider must be continuing to seek reimbursement for services provided to the same patient or even that the grandfathered provider must have been actually reimbursed. For example, the phrase "continue to claim reimbursement" applies to PEBB and OEBB, but to our knowledge PEBB and OEBB did not cover ABA on the effective date of SB 365.[8]

2. Do Oregon's quantitative statutory coverage minimums violate federal mental health parity?

MHPAEA generally prohibits issuers that provide mental health or substance use disorder benefits from imposing financial or treatment benefit limitations that are more restrictive than those applied to medical and surgical benefits in the same classification.[9]

The final rule implementing MHPAEA became effective for plan years beginning on or after July 1, 2014.[10] The final rule distinguishes between quantitative treatment limitations and nonquantitative treatment limitations for assessing parity compliance. A quantitative treatment limitation is expressed numerically (*e.g.*, limitations on the frequency of treatment or the number of visits).[11] An insurer may not impose a quantitative treatment limitation on mental health benefits that is more restrictive than the limitation it applies to substantially all (i.e. at least two-thirds) of medical or surgical benefits in the same classification. If a quantitative treatment limitation applies to at least two-thirds of medical benefits in the same classification, it must be no more restrictive than the predominant limitation of that type. The predominant limitation is

[8] Under SB 365 § 23, the health benefit plan provision of SB 365 applies to commercial health plans for coverage beginning on or after January 1, 2016 and to PEBB and OEBB a year earlier. The PEBB and OEBB Boards have voted to accelerate ABA coverage, PEBB to August 1, 2014, and OEBB to October 1, 2014.

[9] 29 USC 1185a.

[10] The final rule applying to the group insurance market is 45 CFR §146.136. This rule is applied to individual markets by 45 CFR §147.160.

[11] 45 CFR §146.136(a) (definition of *Treatment limitations*).

the level that applies to more than half the medical benefits in the classification. The final rule has detailed methodologies for the determining treatment limitations and predominant limitations, the "substantially all" test, financial requirements, and the classification of benefits.[12]

Oregon statutes impose at least three quantitative requirements that may be relevant to ABA:

a) SB 365 requires coverage for ABA treatment for ASD for up to 25 hours per week. SB 365 §§ 2(1)(f), 2(2)(b).

b) Section 2(1)(b) of SB 365 requires a health benefit plan to provide coverage "for an individual who begins treatment before nine years of age."

c) ORS 743A.168(4)(a)(B) states that nothing in Oregon's mental health parity law requires coverage for "[a] long-term residential mental health program that lasts longer than 45 days."

Significantly, these statutes do not limit coverage. They only express floors.[13] Nothing prohibits an insurer from providing coverage exceeding the quantitative floor. On its face, then, these statutes do not enforce restrictions that directly constitute quantitative treatment limitations under MHPAEA.

That said, if a state law requires that an insurer provide some quantity of coverage for mental health or substance use services, the insurer's coverage must be provided in parity with medical and surgical benefits under MHPAEA. Doing so may require an insurer to provide mental health or substance use disorder benefits beyond the state law minimum.[14] Thus, to comply with MHPAEA, an insurer that imposes any quantitative floor as a limitation on ABA coverage would have to impose the same predominant limitation on at least two-thirds of medical and surgical benefits of the same classification.

3. Is ABA a "medical service" required by the PDD mandate?

ORS 743A.190, the statute mandating services for PDD, provides (with emphasis added):

> A health benefit plan, as defined in ORS 743.730, must 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, including rehabilitation services*, that are medically necessary and are otherwise covered under the plan.

To understand the emphasized phrase, we first examine the text of the statute. Although the statute does not define "medical services," it does define rehabilitation services, as follows:

> "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

[12] 45 CFR §146.136(c).

[13] SB 365 provides that it does not limit coverage for any services that are otherwise available to an individual, including but not limited to "[a]pplied behavior analysis for more than 25 hours per week." SB 365 § 2(9)(b).

[14] Preamble to MHPAEA final rules, 78 Federal Register 68240, 68252 (Nov 13, 2013).

While physical therapy is a service for physical medical conditions, occupational therapy and speech therapy are behavioral services. Since the statutory text includes rehabilitation services among medical services, the mandate for medical services requires at least some of both behavioral and physical services. ABA is a behavioral service like occupational therapy and speech therapy. Like them, ABA is therefore included among "all medical services."

The statutory context also supports this interpretation. SB 365 uses the adjective "medical" in the phrase "medical necessity" and the cognate phrase "medically necessary" which expressly apply to "all covered services." "Covered services" in turn are a subset of "medical services," namely those that are "otherwise covered under the plan." The definition of "medically necessary" requires the standard to apply "uniformly to all covered services," implying that behavioral and physical services must have uniform medical necessity definitions. Other pre-existing statutes in the Insurance Code either use "medical services" comprehensively, in a way that includes behavioral services,[15] or use it to describe health care services other than hospital services (and sometimes also other than surgical services).[16] Specifically, the Insurance Code uses "medical services" in this way when the services obviously must include behavioral ones.[17] To be sure, Oregon's mental health parity mandate refers to a "behavioral health or medical professional,"[18] but we do not believe that the PDD statute was picking up that distinction.

The one place where the PDD legislation contrasts medical and behavioral is in Section 2a of the bill, which required that the Oregon Health Resources Commission "review ... available medical and behavioral health evidence on the treatment of pervasive developmental disorders" and report back to the legislature. Here, medical and behavioral are indeed opposed, but the opposition concerns two different kinds of evidence, not two different kinds of services. In fields like psychiatry, medical and behavioral evidence are distinguished, which does not imply that psychiatry as a whole is anything other than a medical service.

The standard dictionary definition of "medical" is (1) of, relating to, or concerned with physicians or with the practice of medicine often as distinguished from surgery, or (2) requiring or devoted to medical treatment—distinguished from surgical.[19] The first of these definitions cannot apply in light of the statute's express inclusion of rehabilitative services, which are not concerned with physicians or with the practice of medicine. As for distinguishing medical treatment from surgical, health insurance policies today virtually always combine medical and surgical coverage, so it seems unlikely that the Legislature intended to mandate medical as opposed to surgical coverage. The standard dictionary definition is therefore unhelpful.

---

[15] See, e.g., ORS 743A.012(1)(c)(definitions of emergency services and stabilization services); ORS 743A.064 (urgent medical condition)

[16] See e.g. ORS 743A.001(2)(a)(referring to "hospital, medical, surgical or dental health services"); ORS 743A.050(1), 743A.100(1), 743A.108(1), 743A.120(1), 743A.12(4)(1), 743A.144(1), 743A.148(1) (referring to "hospital, medical or surgical expenses").

[17] E.g. ORS 743A.160 (alcoholism treatment).

[18] ORS 743A.168 (1)(e)(A)(v).

[19] *Webster's Third New International Dictionary of the English Language Unabridged* (1993).

In place of the standard dictionary definition, the Oregon Supreme Court has recently been willing to use industry definitions for technical terms.[20] The phrase "medical services" here is best defined by reference to its usage in the insurance industry, not its meaning in the world at large. In the NAIC consumer glossary, "Medical Only" is defined as the "line of business that provides medical only benefits without hospital coverage. An example would be provider-sponsored organizations where there is no coverage for other than provider (non-hospital) services."[21] Best's "Glossary of Insurance Terms uses "medical" as a synonym for "health care."[22] Neither definition contrasts medical services with behavioral services.

The legislative history indicates that the bill's purpose was to provide coverage for a range of services that a child diagnosed with PDD may need, and for which coverage was being denied solely because a child was suffering from PDD.[23] For example, Representative Sara Gelser, the co-author and co-sponsor of the bill, testified that "[t]he intention of this bill is to ensure that kids who have disabilities can have access to the medical care they need, whether that's physical health care … related to autism or rehabilitation services that might be needed by a child with a more general developmental disorder or developmental delay."[24] Rep. Gelser clarified that such services could include physical therapy or occupational therapy to improve the independence of a child suffering from PDD. That history suggests that the bill supporters were concerned with providing coverage for a broad range of services needed to treat PDD symptoms, and not just coverage for unrelated medical conditions.

Our conclusion is same as the one arrived at by the US District Court in *A.F. v. Providence*. While the court did not find it necessary to decide whether ABA therapy is a "medical service," the court did say: "If the Court were to interpret 'medical services,' it would find, and does find in the alternative, that ABA therapy is a medical service."[25]

---

[20] *Comcast Corporation v. Department of Revenue*, 356 Or 282 (Oct 2, 2014).

[21] http://www.naic.org/consumer_glossary.htm#M.

[22] E.g. "Point-of-Service Plan - Health insurance policy that allows the employee to choose between in-network and out-of-network care each time medical treatment is needed"; "Preferred Provider Organization - Network of *medical* providers who charge on a fee-for-service basis, but are paid on a negotiated, discounted fee schedule." http://www.ambest.com/resource/glossary.html (emphasis added).

[23] The exhibits to the bill include a letter from an insurance company denying coverage for rehabilitative services to a child with PDD because the child's speech delay was "attributed to a congenital condition and there has been no lost function due to an illness or injury."

[24] Testimony, Senate Committee on Health Policy and Public Affairs, HB 2918, May 30, 2007 (statement of Rep. Sara Gelser).

[25] Footnote four of *A.F. v. Providence Health Plan, Case No. 3:13-cv-00776-SI, United States District Court, D. Oregon (August 8, 2014)* reads in full:

> If the Court were to interpret "medical services," it would find, and does find in the alternative, that ABA therapy is a medical service. Looking to the text and the context, the statute provides that a health benefit plan must cover "all medical services, including rehabilitation services, that are medically necessary and otherwise covered." ORS 743A.190(1). "Rehabilitation services" is defined as "physical therapy, occupational therapy or speech therapy services to restore or improve function," but "medical services" is not explicitly defined in the statute. ORS 743A.190(3). Plaintiffs argue that ABA therapy, like "physical therapy, occupational therapy or speech therapy," is a therapy service meant to "restore or improve function," and that therefore, ABA fits within the "plain, natural, and ordinary" definition of medical services if these other types of rehabilitation services fit within the definition of medical services. ABA is a widely accepted therapy that is "firmly supported by decades of research and application and is a well-established treatment modality of autism and other [pervasive developmental disorders]." *McHenry*, 679 F. Supp.

4. In providing ABA services, may an insurer impose exclusions such as those listed in the MHP and ABA mandates?

In explaining the coverage requirements of ORS 743A.168's mandate, bulletins 2014-1 and 2014-2 suggest that insurers may not impose categorical or other broad-based treatment exclusions (e.g., exclusions based on categories such as "academic or social skills training" or "developmental, social or educational therapies") that result in a denial of ABA or other medically necessary care. That does not prohibit using categorical exclusions altogether. Insurers are not prohibited from imposing categorical limitations or exclusions as related to mental health, PDD- or ABA-specific coverage. On the contrary, ORS 743A.168 and SB 365 expressly permit certain exclusions and limitations.

ORS 743A.168(4)(a) exempts the following categories from the MHP coverage mandate:

> (A) Educational or correctional services or sheltered living provided by a school or halfway house;
>
> (B) A long-term residential mental health program that lasts longer than 45 days;
>
> (C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;
>
> (D) A court-ordered sex offender treatment program; or
>
> (E) A screening interview or treatment program under ORS 813.021.

Section 2(3) of SB 365 similarly exempts the following services from the ABA coverage mandate:

> (a) Services provided by a family or household member;
>
> (b) Services that are custodial in nature or that constitute marital, family, educational or training services;
>
> (c) Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or hyperbaric chambers;
>
> (d) Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq.;

2d at 1237. Based on the text and context of the statute—including the statutory definition of "rehabilitation services"—the Court agrees that ABA therapy fits within the ordinary definition of medical services. Accord *Hummel v. Ohio Dep't of Job & Family Servs.*, 844 N.E.2d 360, 366 (Ct. App. Ohio 2005) (interpreting "medical service" to include ABA therapy under the ordinary definition); *K.G. ex rel. Garrido v. Dudek*, 839 F. Supp. 2d 1254, 1276-77 (S.D. Fl. 2011) (holding that ABA therapy is a medical service that must be covered under Medicaid), affirmed in relevant part *Garrido v. Dudek*, 731 F.3d 1152 (11th Cir. 2002); *Chisholm ex rel. CC, MC v. Kliebert*, 2013 WL 3807990, at *22 (E.D. La. July 18, 2013) (holding that ABA therapy when recommended by a physician or psychologist constitutes "medical assistance").

(e) Services provided through community or social programs; or

(f) Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority.

Taken together, these provisions manifest the legislature's intent that insurers to be able to impose many established categories of exclusions and limitations to the coverage required under ORS 743A.168, ORS 743A.190, and SB 365.

However, recent federal court cases have limited permissible categorical exclusions. In particular, a categorical limitation is not permitted under Oregon's mental health coverage mandate if the limitation entirely precludes coverage for medically necessary treatment for a mental health condition. For example, in *A.F. v. Providence Health Plan*, the federal court held that an insurer's exclusion for all services "related to a developmental disability" effectively barred coverage for autism (a developmental disability), and therefore violated ORS 743A.168's parity requirement because no similar exclusion barred coverage for the treatment of any medical condition.[26] Similarly the federal court in *McHenry v. Pacificsource Health Plans*, in light of the mandate in ORS 743A.168, construed exclusions for experimental or investigational procedures, educational services, and academic and social skills training to allow coverage of ABA.[27] In other words, an insurer cannot satisfy Oregon mental health coverage mandates if the insurer adopts a categorical exclusion that effectively denies coverage for the very services necessary to treat a specific mental health condition. That same reasoning logically extends to the PDD- and ABA-coverage requirements under ORS 743.190 and SB 365.

This reasoning finds support in the recent Washington Supreme Court case of *O.S.T .v. Regence Blueshield*.[28] It construes two Washington statutes: the neurodevelopmental therapies mandate, RCW 48.44.450, and the mental health parity act, RCW 48.44.34. The first of these is similar to Oregon's PDD statute, and the second is similar to Oregon's MHP statute. The court's conclusion that the insurer's blanket exclusion violated mental health parity resembles and reinforces the conclusion in *A. F. v. Providence.*

[26] The court described Providence's exclusion as "a blanket exclusion for an entire family of mental health diagnoses." It explained:

> By stating that it covers autism (a developmental disability), but excluding coverage for all services "related to a developmental disability," Providence is not covering treatment for mental health conditions in parity with treatment for medical conditions. Providence cannot identify any medical condition covered by its plan where there was an exclusion that could, on its face, deny coverage for all services "related to" the treatment for that condition. Moreover, Providence cannot provide any examples of a medical condition where an exclusion was used to deny coverage of the primary and widely-respected medically necessary treatment for that medical condition. Because of the broad-based Developmental Disability Exclusion, Providence covers mental health conditions at a different level than medical conditions in violation of the parity obligations.

[27] *McHenry v. Pacificsource Health Plans*, 679 F.Supp.2d 1226 (D. Or. 2010)

[28] *O.S.T .v. Regence Blueshield*, 88940-6, 2014 WL 5088260, (October 9, 2014)

5. May an insurer apply to ABA the managed care provisions of the Oregon MHP and PDD statutes, such as credentialing, cost sharing, treatment limitations, utilization review, and network contracting?

Oregon's MHP statute allows "managing the provision of benefits through common methods."[29] Specifically, the statute allows mandated mental health treatment to be subject to ordinary managed care procedures: credentialing,[30] policy provisions including cost sharing,[31] treatment limitations,[32] medical necessity determinations,[33] utilization review,[34] and provider network contracting.[35]

For example, ORS 743A.168(2) states that coverage for mental health conditions may be made subject to deductibles and coinsurance requirements, provided they are no greater than those required for other medical conditions. Likewise, ORS 743A.168(3) permits treatment limitations, limits on total payment for treatment, limits on duration of treatment, or other financial requirements, as long as "similar limitations or requirements are imposed on coverage of other medical conditions." ORS 743A.168(3) similarly permits insurers to limit coverage of mental health and substance abuse to medically necessary treatment, but requires a determination of medical necessity to be made according to the same standard applicable for other medical conditions.

ORS 743A.190, which requires health benefit plans to cover treatment of PDDs for a child, likewise permits coverage to be made subject to "other provisions of the health benefit plan that apply to covered services." Under ORS 743A.190(2), those limitations include, but are not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

---

[29] "Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section." ORS 743A.168(8).

[30] " 'Provider' means a person that [h]as met the credentialing requirement of a group health insurer ***." ORS 743A.168(1)(e)(A).

[31] "The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance." ORS 743A.168(2).

[32] "The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions." ORS 743A.168(3).

[33] "The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions." ORS 743A.168(3).

[34] "The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference." ORS 743A.168(9).

[35] "Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers." ORS 743A.168(11).

(c) Treatment limitations regarding the number of visits or the duration of treatment.

As with categorical exclusions, these provisions must be applied in a way that does not effectively deny all coverage for ABA. For example, as we have discussed above, an insurer may impose credentialing requirements on ABA providers, but the insurer may not discriminate against all practitioners of ABA and should ensure access to ABA.

6. May an insurer use the parameters of 2013 SB 365 before its effective date as a framework for benefit administration in order to comply with the bulletins?

Some insurers have already begun covering ABA. In so doing, one option is to use the parameters of SB 365 as the framework for ABA benefit administration, even though SB 365 is not yet effective as to commercial health insurance. This is a completely lawful approach open to any insurer seeking a path to comply with OID's bulletins.

Even though SB 365 has yet to go into full effect, nothing prohibits an insurer from using SB 365 as a framework for current benefit administration. For example, an insurer may require submission of an individualized treatment plan under SB 365 section 2(6); if an insurer provides ABA coverage in advance of the effective date of section 2, no law precludes the insurer from requiring submission of an individualized treatment plan for ABA patients.

However, an insurer that chooses to rely on SB 365 should be mindful of the parity concerns laid out above. In particular, as previously noted, some provisions of SB 365 (e.g., the 25 hours per week treatment limitation), if implemented by an insurer as a limitation, would be a quantitative treatment limitation under the federal MHPAEA. As a result, insurers seeking to impose such a limitation on ABA coverage provided under their plan should consider whether the limitation would pass MHPAEA parity requirements. Similarly, to use the example above, an insurer that requires submission of an individualized treatment plan for ABA patients must satisfy MHPAEA requirements for non-quantitative treatment limits.

7. To what extent may the Division rely on A. F. v. Providence, even though that is a District Court opinion still subject to appeal?

In preparing the bulletins, OID wisely examined case law from many jurisdictions. The Appendix to Bulletin 2014-2 tabulates these cases.

When the highest court with jurisdiction—the Oregon Supreme Court for Oregon law, the US Supreme Court for federal law—has ruled on a legal issue, OID is bound to follow. For most legal issues, however, the highest court will not have ruled. The highest courts have not ruled on any of the issues discussed here. Given this legal uncertainty, OID has authority to make regulatory judgments, taking into account extant case law and DOJ advice where the law is uncertain.

For interpretation of Oregon statutes, of course we examine particularly cases applying or decided under Oregon law. To date those are *A. F. v. Providence* and *McHenry v. PacificSource*, both already cited. But those courts considered precedents from other jurisdictions. Cases decided under the law of other states can often be helpful, like the Washington Supreme Court case we mentioned.

8. May the Division reasonably make the bulletins effective August 8, 2014?

The contracts clauses of state and federal constitutions prohibit passage of new laws that impair obligations of existing contracts.[36] The bulletins, however, do not pass new laws. Rather they interpret laws already in effect on the stipulated effective date and thus do not impair obligations of contract.

The *A. F. v. Providence* decision marked the date on which OID achieved sufficient clarity on the interpretation of Oregon statutes to support the position taken in the bulletins. *A. F. v. Providence* provided unusually clear guidance: it is a class action (*McHenry* involved just one consumer), it was on summary judgment, it arrived at the same result under three separate statutes including MHPAEA, and it is part of a statewide and nationwide trend. At around the same time, three other Oregon agencies—PEBB, OEBB, and the Health Evidence Review Commission (HERC)—also decided to allow ABA coverage.

Although the bulletins address many issues in addition to the categorical exclusions that *A. F. v. Providence* addressed, OID has considerable discretion in determining when its interpretations of statutes become effective. OID's decision to use the date of *A. F. v. Providence* as the effective date for the Bulletins does not deprive OID its authority to review earlier claims.

Please contact us as follow-up questions may arise. Pursuant to ORS 180.060(3), persons other than state officers may not rely upon this letter.

Regards,

Theodore C. Falk
Attorney-in-Charge

[36] Or. Const. Art I, § 21; U.S. Const. Art. I, § 10, Cl. 1.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

A.F., by and through his parents and guardians, Brenna Legaard and Scott Fournier; and A.P., by and through his parents and guardians, Lucia Alonso and Luis Partida, and on behalf of similarly situated individuals,

Plaintiffs,

v.

PROVIDENCE HEALTH PLAN,

Defendant.

Case No. 3:13-cv-00776-SI

OPINION AND ORDER

Keith S. Dubanevich, Joshua L. Ross, and Nadine A. Gartner, STOLL STOLL BERNE LOKTING & SHLACHTER, P.C., 209 S.W. Oak Street, Suite 500, Portland, OR 97204; Megan E. Glor, MEGAN E. GLOR, ATTORNEYS AT LAW P.C., 621 S.W. Morrison Street, Suite 900, Portland, OR 97205. Of Attorneys for Plaintiffs.

William F. Gary, Arden J. Olson, and Aaron Landau, HARRANG LONG GARY RUDNICK, P.C., 360 East 10th Avenue, Suite 300, Eugene, OR 97401; Aaron T. Bals, HARRANG LONG GARY RUDNICK, P.C., 1001 S.W. Fifth Avenue, Suite 1650, Portland, OR 97204. Of Attorneys for Defendant.

Michael H. Simon, District Judge.

Autism Spectrum Disorder is a pervasive developmental disorder that begins to appear during early childhood and is characterized by impairments in communication and social skills,

severely restricted interests, and repetitive behavior. Applied Behavior Analysis ("ABA") is an early intensive behavioral interaction health service that helps people with autism to perform social, motor, verbal, behavior, and reasoning functions that they would not otherwise be able to do. Plaintiffs A.F. and A.P. (collectively "Plaintiffs") are both covered as dependent-beneficiaries under group health insurance plans issued by Defendant Providence Health Plan ("Providence"). A.F. and A.P. were denied coverage of ABA therapy by Providence—both initially and on appeal—based on Providence's "Developmental Disability Exclusion."

Plaintiffs bring this class action lawsuit, alleging that Providence's denial of ABA therapy on the basis of its Developmental Disability Exclusion violates the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*; the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("Federal Parity Act"), 29 U.S.C. § 1185a; and two Oregon state laws, Or. Rev. Stat. §§ 743A.168 and 743A.190. Plaintiffs moved for class certification, which the Court granted. The parties have agreed that the Court should treat their pending motions as cross motions for partial summary judgment. For the reasons that follow, the court grants partial summary judgment for Plaintiffs and denies Defendant's cross motion. Providence's Developmental Disability Exclusion violates both the Federal Parity Act and Oregon law and is therefore prohibited under ERISA.

STANDARDS

A. De Novo Review

Judicial review of an ERISA-governed insurance policy that grants the insurer discretion to determine a claimant's eligibility for benefits is ordinarily reviewed for "abuse of discretion." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). When a court reviews questions of statutory interpretation, however, it owes no deference to the insurer's decision and reviews legal questions *de novo*. *Long v. Flying Tiger Line, Inc. Fixed Pension Plan for Pilots*,

994 F.2d 692, 694 (9th Cir. 1993). The issues presented in the pending motions are questions of statutory interpretation.

B. Motion for Summary Judgment

A party is entitled to summary judgment if the "movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The moving party has the burden of establishing the absence of a genuine dispute of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The court must view the evidence in the light most favorable to the non-movant and draw all reasonable inferences in the non-movant's favor. *Clicks Billiards Inc. v. Sixshooters Inc.*, 251 F.3d 1252, 1257 (9th Cir. 2001). Although "[c]redibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions, not those of a judge . . . ruling on a motion for summary judgment," the "mere existence of a scintilla of evidence in support of the plaintiff's position [is] insufficient . . . ." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252, 255 (1986). "Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no genuine issue for trial." *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (citation and quotation marks omitted).

Where parties file cross-motions for summary judgment, the court "evaluate[s] each motion separately, giving the non-moving party in each instance the benefit of all reasonable inferences." *A.C.L.U. of Nev. v. City of Las Vegas*, 466 F.3d 784, 790-91 (9th Cir. 2006); *see also Pintos v. Pac. Creditors Ass'n*, 605 F.3d 665, 674 (9th Cir. 2010) ("Cross-motions for summary judgment are evaluated separately under [the] same standard."). In evaluating the motions, "the court must consider each party's evidence, regardless under which motion the evidence is offered." *Las Vegas Sands, LLC v. Nehme*, 632 F.3d 526, 532 (9th Cir. 2011). "Where the non-moving party bears the burden of proof at trial, the moving party need only

prove that there is an absence of evidence to support the non-moving party's case." *In re Oracle Corp. Sec. Litig.*, 627 F.3d 376, 387 (9th Cir. 2010). Thereafter, the non-moving party bears the burden of designating "specific facts demonstrating the existence of genuine issues for trial." *Id.* "This burden is not a light one." *Id.* The Supreme Court has directed that in such a situation, the non-moving party must do more than raise a "metaphysical doubt" as to the material facts at issue. *Matsushita*, 475 U.S. at 586.

BACKGROUND

Plaintiffs A.F. and A.P. are both insured as dependent-beneficiaries under group health plans in Oregon provided by Providence. A.F. and A.P. have both been diagnosed with Autism Spectrum Disorder and prescribed ABA therapy by their treating physicians. ABA therapy is an intensive behavior therapy that, among other things, measures and evaluates observable behaviors. Evidence shows that ABA therapy may help autistic children with cognitive function, language skills, and adaptive behavior. Evidence also suggests that the benefits of ABA are significantly greater with early intervention for young autistic children. Before January 2014, Providence denied all requests for coverage of ABA therapy.

In 2012, Providence denied a request by A.F.'s parents for reimbursement for the expenses of ABA therapy. A.F.'s parents appealed the initial denial, which Providence also denied. When A.F.'s parents appealed a second time, Providence denied the second appeal and provided this explanation:

> Under the language of the Oregon Group Member Handbook for Open Option Plans, services "related to developmental disabilities, developmental delays or learning disabilities" are specifically excluded from coverage under this plan. (See Group Member Handbook, at 43). There is no question that autism spectrum disorder is a "developmental disability" or involves "developmental delay," and PHP [Providence Health Plan] here has so interpreted it, in this case as it has in other cases seeking ABA services for autism spectrum disorder. Because ABA

> services are related to autism spectrum disorder, they are therefore not benefits covered under the plan.

Declatation of Joshua L. Ross ("Ross Decl.") Ex. C at 9., Dkt. 41-3.

Also in 2012, Providence denied the request by A.P.'s physician for authorization of ABA therapy to treat A.P.'s autism. A.P.'s parents appealed Providence's denial, and Providence denied the appeal. Providence provided the following explanation, which is almost identical to the explanation provided to A.F., to A.P.'s parents:

> Under the language of the Oregon Group Member Handbook for Open Option Plans, mental health services "related to developmental disabilities, developmental delays or learning disabilities" are specifically excluded from coverage under this plan. (See Group Member Handbook, at 41). There is no question that autism spectrum disorder is a "developmental disability" or involves "developmental delay," and Providence as the plan administrator here has so interpreted it, in this case as it has in other cases seeking ABA services for autism spectrum disorder. Because ABA services are mental health services related to autism spectrum disorder, they are therefore not benefits covered under the plan.

Ross Decl. Ex. D at 8., Dkt. 41-4.

Thus, in both cases, Providence denied coverage of ABA therapy because it is a service "related to developmental disabilities, developmental delays or learning disabilities." *Id.* This exclusion (hereinafter, "the Developmental Disability Exclusion") is included in all of the group plan insurance contracts issued by Providence after 2007. The Developmental Disability Exclusion is listed in the member handbook given to all members that describes the governing terms of the insurance plans.

Providence issues two types of plans: "self-insured" group plans and "insured" group plans. Under a "self-insured" plan, the employer carries the risk of coverage. Under an "insured" plan, Providence carries the risk of coverage. Both the "self-insured" and "insured" plans are subject to Oregon law and ERISA. Plaintiffs and all class members are members of "insured"

group plans. Providence is both the administrator of these plans and a fiduciary to all plan members. As such, Providence is obligated to apply exclusions consistently and uniformly.

Providence uses diagnosis codes and current procedural terminology ("CPT") codes to process members' claims. The diagnosis codes for Autism Spectrum Disorder all start with 299. There is no CPT code for ABA therapy.

Although Providence's group plans differ in terms of the specific benefits provided to group members, all of the group plan contracts issued after January 1, 2007 contain several identical provisions, including: (1) coverage for "Mental Health Services;" (2) a definition of "Mental Health Services" that includes coverage of autism; and (3) exclusion of coverage for "services related to developmental disabilities, developmental delays, or learning disabilities" (the Developmental Disability Exclusion). Before 2014, Providence denied coverage of ABA therapy under the Developmental Disability Exclusion for all group members under all group plans, regardless of whether the member seeks reimbursement for payments for ABA therapy or pre-authorization of coverage.

Plaintiffs previously moved to certify the class. The Court granted class certification and defined the class to include the following persons:

> All individuals: (a) who are, or will be up to the date of class certification, beneficiaries of an ERISA health benefit plan (i) that is subject to Oregon law, (ii) that contains an Exclusion for services related to developmental disabilities, developmental delays, or learning disabilities, (iii) and that has been or will be issued for delivery, or renewed, on or after January 1, 2007 up to the date of class certification, in the state of Oregon, by Providence Health Plan or any affiliate of Providence Health Plan, its predecessors or successors and all subsidiaries or parent entities; (b) who either have been or will be diagnosed, up to the date of class certification, with any diagnosis code beginning with 299 contained in either the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, Fourth Edition) or the International Classification of Diseases, Ninth Edition (ICD-9); and (c) who are

> not (i) a parent, subsidiary, affiliate, or control person of Defendant, (ii) an officer, director, agent, servant or employee of Defendant, (iii) the immediate family member of any such person, or (iv) a class member who has previously released a claim for benefits under a settlement agreement.

A.F. ex rel. Legaard v. Providence Health Plan, ---F.R.D.---, 2013 WL 6796095, at *4 (D. Or. Dec. 24, 2013).

After the Court granted class certification, but before the current motions were fully briefed, Providence changed its policy regarding covering ABA therapy for children with autism. Oregon Senate Bill 365 was passed by the Oregon Legislature in 2013, but is not effective until January 1, 2015. That law requires that insurance companies in Oregon provide coverage for ABA therapy for children eight years of age and younger for up to 25 hours per week. In response to the passage of Oregon Senate Bill 365, Providence decided voluntarily to implement the coverage sooner than required. The parties agree that because the issue in this case is whether the Developmental Disability Exclusion is lawful and because plan members often seek coverage for ABA therapy for more than 25 hours per week and for children over age eight, Providence's decision to implement Oregon Senate Bill 365 early does not render moot the issues raised in this lawsuit.

DISCUSSION

A. ERISA Civil Enforcement

Plaintiffs argue that Providence's denial of coverage of ABA under the Developmental Disability Exclusion is unlawful in three ways: (1) by violating the Oregon Mental Health Parity Act, Or. Rev. Stat. § 743A.168; (2) by violating the Oregon Mandatory Coverage for Minors with Pervasive Developmental Disorders Act, Or. Rev. Stat. § 743A.190; and (3) by violating the Federal Parity Act, 29 U.S.C. § 1185a. Plaintiffs bring each of these claims under the ERISA civil enforcement provision, 29 U.S.C. § 1132(a)(3), which provides a cause of action for

violations of ERISA itself and, under certain circumstances, violations of state law regulating insurance.

Plan participants and beneficiaries of group policies may bring actions under ERISA's civil enforcement provision to challenge violations of ERISA and the terms of ERISA plans. The ERISA civil enforcement provision provides:

> A civil action may be brought . . . by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3). Because the Federal Parity act is enacted as part of ERISA, it is enforceable through a cause of actions under § 1132(a)(3) as a violation of a "provision of this subchapter." *See id.* Or. Rev. Stat. §§ 743A.168 and 743A.190, on the other hand, are, for the reasons discussed below, enforceable through a cause of action under § 1132(a)(3) as "terms of the plan." *Id.*

It is a general principle of insurance law that all insurance plans include all applicable requirements and restrictions imposed by state law. 2 *Couch on Insurance* § 19:1 (3d ed. 2011). State law regulating insurance thus "enter[s] into and form[s] a part of all contracts of insurance to which [it is] applicable." *Id.* When an insurance policy provision is "in conflict with, or repugnant to, statutory provisions which are applicable to the contract," the inconsistent insurance policy provisions are invalid "since contracts cannot change existing statutory laws." *Id.* at § 19:3. Moreover, when such a conflict exists, "the statutory requirements supersede the conflicting policy provisions and become part of the insurance policy itself." *Id.*

The Supreme Court has repeatedly held that state law regulating insurance applies to ERISA insurance plans, despite the fact that other state laws are preempted by ERISA. *See*

UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 376 (1999) ("We have repeatedly held that state laws mandating insurance contract terms are saved from preemption under § 1144(b)(2)(A)."); *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 733 (1985) (discussing the ERISA insurance savings clause, which states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance") (quoting 29 U.S.C. § 1144(b)(2)(a)) (quotation marks omitted). Section 1144(b)(2)(A), which has come to be known as the "savings clause," states: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). Therefore, the general rule of insurance law—that insurance contracts are subject to and incorporate relevant state law regulating insurance—applies with equal force to ERISA insurance plans.[1] To the extent that Oregon insurance regulations are in conflict with the provisions of Providence's plans, those regulations will "become part of the insurance policy itself." *See Couch on Insurance* § 19:3.

Thus, because the ERISA civil enforcement provision allows courts to enjoin or provide other appropriate equitable relief when a practice violates any "terms of the plan," and because state law regulating insurance, when in conflict with terms of an insurance plan, "supersede the conflicting policy provisions and become part of the plan itself," *see Couch on Insurance* § 19:3, ERISA provides courts with the power to enjoin violations of state law regulating insurance that

[1] Oregon's insurance coverage mandates are also incorporated into Providence's insurance policy as a matter of express contract: "The laws of the State of Oregon govern the interpretation of this Group Contract and the administration of benefits to members, except as provided in section 14.11 [addressing non-transferability of benefits]." Decl. Brenna Legaad Ex. 1, at 77, Dkt. 62.

have become part of the terms of the plan. *See, e.g.*, *Harlick v. Blue Shield of Cal.*, 686 F.3d 699, 721 (9th Cir. 2012) *cert denied* 133 S. Ct. 1492 (U.S. 2013).[2]

B. Plaintiffs' ERISA Claims for Violation of Or. Rev. Stat. §§ 743A.168 and 743A.190

1. Oregon Statutory Interpretation

Plaintiffs argue that Providence's Developmental Disability Exclusion violates two Oregon laws: Or. Rev. Stat. § 743A.168 and § 743A.190. The Court interprets these statutes applying Oregon statutory interpretation principles. *Powell's Books, Inc. v. Kroger*, 622 F.3d 1202, 1209 (9th Cir. 2010) (a federal court interpreting Oregon law should "interpret the law as would the [Oregon] Supreme Court" (alteration in original)). Under Oregon law, the "first step" of statutory interpretation is an examination of the text and context of the statute in order "to discern the intent of the legislature. *Portland Gen. Elec. Co. v. Bureau of Labor & Indus.*, 317 Or. 606, 610 (1993), *superseded by statute*, Or. Rev. Stat. § 174.020; *see State v. Gaines*, 346 Or. 160, 171 (2009) (explaining that Or. Rev. Stat. § 174.020 did not alter the *Portland General Electric* holding regarding the first step of statutory interpretation). "[A]fter examining the text and context," the court will "consult" the legislative history, "even if the court does not perceive an ambiguity in the statute's text, where that legislative history appears useful to the court's analysis." *Gaines*, 346 Or. at 172. The "evaluative weight" given to the legislative history is for the court to determine. *Id.* At "the third[] and final step[] of the interpretive methodology," if "the legislature's intent remains unclear after examining text, context, and legislative history, the

[2] Providence cites *Haviland v. Metropolitan Life Insurance Co.*, 876 F. Supp. 2d 946 (E.D. Mich. 2012), *aff'd*, 730 F.3d 563 (6th Cir. 2013), *cert denied*, 134 S. Ct. 1790 (2014), for the proposition that ERISA preempts state law and then argues that Plaintiffs are not entitled to ERISA relief for violations of state law. The *Haviland* case, however, addressed a state consumer protection law, which is a state law that did not regulate the insurance industry and thus was not "saved" by ERISA § 1144(b)(2)(A). The *Haviland* case, therefore, does not assist Providence in the pending lawsuit.

court may resort to general maxims of statutory construction to aid in resolving the remaining uncertainty." *Id.*

2. Oregon Mental Health Parity Act

The Oregon Mental Health Parity Act, Or. Rev. Stat. § 743A.168, requires parity among the services and treatment covered for *medical* conditions and the services and treatment covered for *mental health and chemical dependency* related conditions. The statute states in relevant part:

> A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

Or. Rev. Stat. § 743A.168. After the enactment of the Oregon Mental Health Parity Act, several Oregon Administrative Rules were issued to help interpret the statute. "Validly promulgated administrative rules have the force of law." *Haskins v. Emp't Dep't*, 156 Or. App. 285, 288 (1998) (en banc). "Administrative rules and regulations are to be regarded as legislative enactments having the same effect as if enacted by the legislature as part of the original statute." *Bronson v. Moonen*, 270 Or. 469, 476 (1974).

One particularly relevant administrative rule interpreting § 743A.168 is Oregon Administrative Rule 836-053-1405(1), which provides:

> A group health insurance policy issued or renewed in this state shall provide coverage or reimbursement for **medically necessary** treatment of mental or nervous conditions . . . at the same level as, and subject to limitations no more restrictive than those imposed on coverage or reimbursement for medically necessary treatment for other medical conditions.

Or. Admin. R. 836-053-1405(1) (emphasis added). Additionally, Oregon Administrative Rule 836-053-1404 defines "mental and nervous conditions" as "all disorders listed in the 'Diagnostic

and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition' except for [certain diagnostic codes not relevant here]." Or. Admin. R. 836-053-1404(1)(a)(A). Autism is a disorder listed in the Diagnostic Statistical Manual of Mental Disorders and the diagnostic code for autism, 299, is not listed among the exceptions. Thus, autism is a "mental and nervous condition" under the Oregon Mental Health Parity Act. *See id.*

Plaintiffs argue that the legislative intent of § 743A.168 was to prohibit such exclusions like the Developmental Disability Exclusion from excluding medically necessary ABA from coverage. Plaintiffs also argue that the statute and related administrative rules state that group health insurance policies "shall" provide coverage of medically necessary services for mental health conditions as other medical conditions and that the ordinary usage of the term "shall" creates a mandatory duty. *See Friends of the Columbia Gorge, Inc. v. Columbia River Gorge Comm'n*, 346 Or. 415, 426-27 (2009). In other words, Plaintiffs contend that Or. Rev. Stat. § 743A.168 "mandates" coverage of ABA therapy.

Providence responds that the phrases "at the same level" and "subject to limitations no more restrictive than" indicate that § 743A.168 is not a coverage mandate for particular services, but rather requires that any *service* that the group plan covers for mental health conditions is covered at the same level as that same service would be covered for other medical conditions. Providence argues that if ABA is not a service covered for *medical* conditions, then Providence is free not to provide ABA for *mental health* conditions.

Looking to the text and context of the statute, Providence's focus on the word "services" is misplaced. The text of the statute requires coverage of treatment for mental health "conditions" at the same level as coverage for medical "conditions." Therefore, although the Oregon Mental Health Parity Act might not mandate coverage of a particular *service*, it does

mandate that Providence cover mental health *conditions* no more restrictively than it covers medical *conditions*. By stating that it covers autism (a developmental disability), but excluding coverage for all services "related to a developmental disability," Providence is not covering treatment for mental health conditions in parity with treatment for medical conditions. Providence cannot identify any medical condition covered by its plan where there was an exclusion that could, on its face, deny coverage for all services "related to" the treatment for that condition. Moreover, Providence cannot provide any examples of a medical condition where an exclusion was used to deny coverage of the primary and widely-respected medically necessary treatment for that medical condition. Because of the broad-based Developmental Disability Exclusion, Providence covers mental health conditions at a different level than medical conditions in violation of the parity obligations.

The Court also notes that if Providence's argument were accepted and insurance companies could cover a mental health condition but exclude coverage for medically necessary services "related to" that condition, the Oregon Mental Health Parity Act would have little to no meaning. For example, Providence could state that it covers depression, but refuse to cover psychotherapy or antidepressant medications, provided that it did not cover psychotherapy or antidepressant medications when those treatments were medically necessary to treat medical conditions. This interpretation is inconsistent with the context of the statute and its purpose to ensure that mental health conditions be covered in parity with medical conditions. Particularly considering that, because of the nature of mental health conditions, in many instances treatment that is medically necessary for mental health diagnoses would never be medically necessary for medical diagnoses. Insurers could thus use a broad exclusion, like the Developmental Disability Exclusion, to get around the parity requirement.

Plaintiffs and Defendant each provided the Court with selections from the legislative history for this statute. The Court has considered this legislative history, but does not find it particularly useful or illuminating in interpreting § 743A.168. Therefore, in accordance with *State v. Gaines*, the Court accords the cited legislative history relatively little evaluative weight. *See Gaines*, 346 Or. at 171. Finally, because the meaning and legislative intent of the Oregon Mental Health Parity Act are clear after examining the text and context of the statute, the Court does not need to apply general maxims of statutory interpretation.[3] *Id.* at 172.

The Court also takes into consideration the fact that other federal courts in this district and state courts across the country have interpreted similar mental health parity acts to require insurance companies to cover ABA therapy under similar circumstances. The persuasive reasoning in these opinions provides further support for the Court's conclusion that § 743A.168 requires insurance companies to cover medically necessary services for covered mental health conditions.

In *McHenry v. PacificSource Health Plans*, 679 F. Supp. 2d 1226 (D. Or. 2010), U.S. Magistrate Judge Stewart analyzed, albeit in dicta, an exclusion of benefits for pervasive developmental disorders ("PDDs"), similar to the Developmental Disability Exclusion, and noted that the then-recently enacted Oregon Mental Health Parity Act resulted in the insurance company abandoning the exclusion. Judge Stewart wrote:

[3] The Court finds the statute's meaning to be clear after considering the text and context of the law. The Court notes, however, that if it were to proceed to step three of the *Gaines* analysis and consider maxims of statutory interpretation, the maxim that statutes should be interpreted to avoid an absurd result would be persuasive on this point. *See Griffin v, Oceanic Contractors, Inc.*, 458 U.S. 564, 575 (1982). The Court would interpret § 743A.168 to avoid the absurd result that insurance companies could decide not to cover medically necessary services for covered mental health conditions (thus obliterating parity) and still be in technical compliance with the Mental Health Parity Act.

> The status of this [PPD] exclusion was brought into question by legislation effective shortly after [the plaintiff's] diagnosis. In August 2005, the State of Oregon enacted the Mental Health Parity Act ("Parity Act"), which went into effect on January 1, 2007. *See* Or. Laws 2005, c. 705, § 1, codified at ORS 743.556 (renumbered ORS 743A.168). The Parity Act mandated that "[a] group health insurance policy providing coverage for hospital or medical expenses" must "provide coverage for expenses arising from treatment for . . . mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions." *Id.* This language required PacificSource to abandon its prior exclusion for PDDs in the 2006 Plan.

Id. at 1233 (footnote omitted). Judge Stewart, although only in dicta, indicated that a PPD would be invalid under the Oregon Mental Health Parity Act.

Similarly, a state appellate court in New Jersey addressed the New Jersey mental health parity act and an exclusion that barred from coverage occupational, speech, and physical therapy. The court wrote:

> [A]n exclusion from coverage for claims based upon occupational, speech, and physical therapy offered to developmentally disabled children would render meaningless the specific inclusion of PDD and autism within those biologically-based mental illnesses subject to the parity statute. . . . To read the governing statute as offering parity, but not affording coverage for medically necessary treatment of the very conditions that are the enumerated subjects of the parity provisions would be unreasonable.

Markiewicz v. State Health Benefits Comm'n, 915 A.2d 553 (N.J. App. Div. 2007); *see also Micheletti v. State Health Benefits Comm'n*, 913 A.2d 842, 849 (N.J. App. Div. 2007) ("If the [plan administrator] is correct in its reading, the statute would appear to promise much, but it really grants little or nothing for an autistic child. We cannot infer such a cruel intent by the Legislature.").

Thus, looking to the text and context of § 743A.168 as well as the persuasive case law, the Court finds that Providence cannot simultaneously purport to cover autism and yet deny

coverage for medically necessary ABA therapy through its Developmental Disability Exclusion consistent with the Oregon Mental Health Parity Act. Because of the Developmental Disability Exclusion, which provides a blanket exclusion for an entire family of mental health diagnoses, Providence is not providing equal coverage of mental health and medical conditions. The Court thus holds that the Developmental Disability Exclusion violates Or. Rev. Stat. §743A.168.

3. Oregon Mandatory Coverage for Minors with Pervasive Developmental Disorders Act

In 2007, the Oregon Legislature passed House Bill 2918, which requires health benefit plans to cover treatment of pervasive developmental disorders for children. The bill, codified as Or. Rev. Stat. § 743A.190, provides:

> (1) A health benefit plan, as defined in ORS 743.730, must 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, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.
>
> (2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:
>
> (a) Deductibles, copayments or coinsurance;
>
> (b) Prior authorization or utilization review requirements; or
>
> (c) Treatment limitations regarding the number of visits or the duration of treatment.

Or. Rev. Stat. § 743A.190(1) and (2). "Pervasive developmental disorder," defined in subsection (3) of the statute, includes "autism spectrum disorder." Or. Rev. Stat. § 743A.190(3)(b). In addition, subsection (3) defines "medically necessary" as "in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan

and that applies uniformly to all covered services under the health benefit plan," and "rehabilitation services" as "physical therapy, occupational therapy or speech therapy services to restore or improve function." Or. Rev. Stat. § 743A.190(3)(a), (c).

Plaintiffs argue that Or. Rev. Stat. § 743A.190 mandates coverage of all medically necessary medical services, including ABA therapy, for children with development disorders under the age of 18. Providence responds that ABA therapy does not fit within the definition of "medical services," that ABA therapy is not "otherwise covered" by Providence's plan, and therefore, that § 743A.190 does not mandate coverage of ABA therapy.

Plaintiffs, however, seek injunctive and declaratory relief, asking the Court to enjoin Providence from denying coverage based on its Developmental Disability Exclusion and to issue a declaration stating that Providence's Developmental Disability Exclusion violates applicable law. Thus, the issue before the Court is not whether Or. Rev. Stat. § 743A.190 mandates coverage of ABA therapy in the abstract, but rather, whether Providence can lawfully use the Developmental Disability Exclusion to deny coverage of ABA therapy—or stated another way, whether the Developmental Disability Exclusion violates Or. Rev. Stat. § 743A.190. Thus, specifically determining whether ABA therapy is a "medical service" that is "otherwise covered" by Providence is unnecessary.[4]

[4] If the Court were to interpret "medical services," it would find, and does find in the alternative, that ABA therapy is a medical service. Looking to the text and the context, the statute provides that a health benefit plan must cover "all medical services, including rehabilitation services, that are medically necessary and otherwise covered." Or. Rev. Stat. § 743A.190(1). "Rehabilitation services" is defined as "physical therapy, occupational therapy or speech therapy services to restore or improve function," but "medical services" is not explicitly defined in the statute. Or. Rev. Stat. § 743A.190(3). Plaintiffs argue that ABA therapy, like "physical therapy, occupational therapy or speech therapy," is a therapy service meant to "restore or improve function," and that therefore, ABA fits within the "plain, natural, and ordinary" definition of medical services if these other types of rehabilitation services fit within the definition of medical services. ABA is a widely accepted therapy that is "firmly supported by

To determine whether the Developmental Disability Exclusion violates Or. Rev. Stat. § 743A.190, the Court first looks to the text and context of the statute and then consults the legislative history to the extent that it is useful. *See Gaines*, 346 Or. at 171-72. The plain text of the statute, cited above, provides that a health plan must cover all medically necessary medical services for children with a pervasive developmental disorder that are otherwise covered. Providence contends that the common sense meaning of "otherwise covered" is that the medical services must be "otherwise covered" for plan members who do *not* have a developmental disorder. *See* Or. Rev. Stat. § 743A.190(1). Plaintiffs argue that the plain and ordinary meaning of "otherwise covered" is that the service would be subject to the plan's other coverage limitations, such as limitations on the number of visits and any "outside of network" physician restrictions. The Court assumes without deciding that Providence's interpretation is correct. The result is the same.

Providence's Developmental Disability Exclusion excludes from coverage services "related to developmental disabilities, developmental delays or learning disabilities." Ross Decl. Ex. D at 8., Dkt. 41-4. Although Providence does not appear to enforce the Developmental Disability Exclusion in all circumstances, on its face, the exclusion exempts from coverage all services related to a plan member's pervasive developmental disability. There are several

---

decades of research and application and is a well-established treatment modality of autism and other [pervasive developmental disorders]." *McHenry*, 679 F. Supp. 2d at 1237. Based on the text and context of the statute—including the statutory definition of "rehabilitation services"—the Court agrees that ABA therapy fits within the ordinary definition of medical services. *Accord Hummel v. Ohio Dep't of Job & Family Servs.*, 844 N.E.2d 360, 366 (Ct. App. Ohio 2005) (interpreting "medical service" to include ABA therapy under the ordinary definition); *K.G. ex rel. Garrido v. Dudek*, 839 F. Supp. 2d 1254, 1276-77 (S.D. Fl. 2011) (holding that ABA therapy is a medical service that must be covered under Medicaid), *affirmed in relevant part Garrido v. Dudek*, 731 F.3d 1152 (11th Cir. 2002); *Chisholm ex rel. CC, MC v. Kliebert*, 2013 WL 3807990, at *22 (E.D. La. July 18, 2013) (holding that ABA therapy when recommended by a physician or psychologist constitutes "medical assistance")

services that would be considered "related to" a developmental disorder—for example speech therapy, physical therapy, and psychotherapy—that are covered by Providence for other plan members.

In other words, if a plan member requested coverage for speech therapy related to his or her developmental disability, Providence *could* deny coverage under the exclusion, but still provide coverage for speech therapy for a different plan member who does not have a developmental disability. Regardless of whether or not Providence chooses always to enforce its Developmental Disability Exclusion, the exclusion on its face directly violates Or. Rev. Stat. § 743A.190. As such, even accepting Providence's interpretation of "otherwise covered," the Developmental Disability Exclusion conflicts with the statute.

Although the plain text of the statute is clear, the legislative history further supports the conclusion that the Developmental Disability Exclusion violates Or. Rev. Stat. § 743A.190. Both parties cited extensive legislative history to support their arguments.[5] For example, in a speech cited by Providence, Representative Sara Gelser explained the purpose of the proposed legislation. She stated:

[5] Plaintiffs cite to the testimony of several advocates and legislators discussing how the bill would provide coverage for ABA therapy. Of particular relevance, is the testimony of Representative Mitch Greenlick in support of the House Bill 2918. Representative Greenlick discussed the United States Surgeon General's statement describing a study of ABA therapy that demonstrated "the efficacy of [ABA] in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." Or. H.R. H. Health Care Subcomm. On Health Care Access, Rep. Mitch Greenlick, H.B. 2918, Mar. 14, 2007, Gartner Decl. Ex. H. This testimony in support of the bill, regarding the importance of ABA therapy, indicates that the legislators believed that ABA therapy would be included in the definition of "medical services." Providence points out that all of this testimony cited by Plaintiffs took place in March of 2007, in support of a previous (and more expansive) version of the bill. The original bill stated: "All health benefit plans, as defined in ORS 743.730, shall provide coverage for treatment of a pervasive developmental disorder that is prescribed by the beneficiary's physician in accordance with a treatment plan." H.B. 2918 § 2(1), 74th Leg. Assemb., Reg. Sess. (Or. 2007) (as introduced). This legislative history regarding an earlier version of the bill is less probative.

> [C]hildren with autism or pervasive developmental delay, learning disabilities, mental retardation are routinely denied services that are available to other members of their family under the same health insurance plan because they are people with learning disabilities, developmental disabilities and developmental delays. . . . And so what this amendment does, basically, is it just creates some equity within an insurance plan that says if speech therapy is covered for Betty in a family, it should also be covered for Ben, even if he has autism, at the same level of coverage that it's offered to Betty.

H. Comm. on Health Care, Testimony of Rep. Sara Gelser, H.B. 2918, April 25, 2007, Olson Decl. Ex 1 at 4, Dkt. 70-1. Representative Gelser's testimony supports, rather than diminishes, the conclusion that the Developmental Disability Exclusion, which could, on its face, in some instances deny a person with a developmental disability a service that is otherwise provided by Providence to plan members without a developmental disability, is in conflict with Or. Rev. Stat. § 743A.190.

The House Staff Member Summary of the bill also interpreted the statute consistently with the Court's interpretation. It specified that the bill ensures "that health benefit plans may not deny benefits to an individual who is covered under the plan due to the diagnosis of pervasive developmental disorder." Staff Measure Summary, H.B. 2918 A, 74th Leg. Assemb., Reg. Sess. (Or. 2007), Olson Decl. Ex 3., Dkt. 70-3. Moreover, after the bill passed the Oregon House of Representatives and the Oregon Senate, Representative Peter Buckley—a member of the Joint Ways and Means Committee—testified as follows:

> We are asking for nothing more or less than what is available to a child without the diagnosis of pervasive developmental disorder or autism. . . . We have compromised down with the insurance companies to only require the same medically necessary benefits for developmentally disordered children that non-developmentally disordered children are offered under the exact same polices.

Joint Comm. On Ways and Means, Transp. & Econ. Dev. Subcomm., Testimony of Rep. Buckley, H.B. 2918, 74th Leg. Assemb. Reg. Sess. (Or. 2007), June 16, 2007, Olson Decl. Ex 5 at 7-8, Dkt. 70-5. Representative Buckley further provided this useful example:

> Two children live on the same street. The evaluations for both children indicate the same need for physical therapy. One child experienced a stroke at four months so has access to covered benefits because it was the result of an illness or injury. The other child, same age, whose disability occurred prior to birth, is given a label of developmental disability and is therefore denied access to the family's covered health benefits.

Id. at 11-12. Representative Buckley concluded by saying that this bill would prevent insurers from covering this first child's physical therapy and not covering the second child's physical therapy. This testimony supports the proposition that the statute prohibits an insurer from refusing to cover a service for a developmentally disabled child that is otherwise covered for other plan members.

The text, context, and legislative history thus make it clear that an insurer cannot provide coverage for a service for one child and deny coverage for the same service for another child solely because the second child suffers from a developmental disability. The Developmental Disability Exclusion, however, would allow just that. It permits Providence to deny coverage for services as "related to a developmental disability" that otherwise would be covered for other plan members who do not have developmental disabilities. Whether or not Providence chooses consistently to enforce the Developmental Disability Exclusion does not matter. On its face, the Developmental Disability Exclusion violates Or. Rev. Stat. § 743A.190.

C. Plaintiffs' ERISA Claim for Violation of the Federal Parity Act

Plaintiffs argue that Providence's Developmental Disability Exclusion is also unlawful under the Federal Parity Act, 29 U.S.C. § 1185a(a)(3)(A)(ii). This law requires that for group health plans, financial requirements and treatment limitations to mental health benefits must be

no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits.[6] Providence argues that the Federal Parity Act, like the Oregon Mental Health Parity Act, does not mandate, or require, coverage of any specific service or treatment, but merely states that if a certain service or treatment is covered, it must be covered equally for medical and mental health conditions.

The Court uses federal principles of statutory interpretation to interpret this federal law. Under these principles, "[s]tatutory interpretation begins with the language of the statute." *UMG Recordings, Inc. v. Shelter Capital Partners LLC*, 718 F.3d 1006, 1026 (9th Cir. 2013) (citation and quotation marks omitted). When terms within a statute are not defined, those terms must be "accorded their plain and ordinary meaning, which can be deduced through reference sources such as general usage dictionaries." *Id.* When determining the meaning of a statute, however, courts "look not only to the particular statutory language, but to the design of the statute as a whole." *Crandon v. United States*, 494 U.S. 152, 158 (1990). Nonetheless, "statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S. 189, 194 (1985).

The Court thus begins its analysis by looking to the text of the Federal Parity Act. In pertinent part, it provides:

> In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

[6] As discussed above, plan participants and beneficiaries of group policies may bring actions under ERISA's civil enforcement provision to challenge Federal Parity Act violations. ERISA provides individual participants and beneficiaries with a basis to challenge a plan for "any act or practice" that violates ERISA provisions, including the Federal Parity Act, which was enacted within ERISA.

> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
>
> (ii) the **treatment limitations** applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

29 U.S.C. § 1185a(3)(A)(i)-(ii) (emphasis added). The law defines "treatment limitation" as follows: "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." 29 U.S.C. § 1185a(3)(B)(iii).

The U.S. Department of Health and Human Services has issued regulations interpreting the Federal Parity Act. In these regulations, the agency explains that the term "treatment limitations" includes both quantitative and nonquantitative limitations:

> Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

45 C.F.R. § 146.136(a); 29 C.F.R. § 2590.712(a). Included in the regulations is an illustrative list of nonquantitative treatment limitations which include, of particular relevance, "[m]edical

management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative." *Id.*

Plaintiffs argue that the Federal Parity Act prohibits Providence from denying ABA therapy under the Developmental Disability Exclusion because it is a "treatment limitation" that is applicable only to mental health disorders. Providence responds primarily with two arguments for the proposition that the Federal Parity Act does not preclude Providence from using the Developmental Disability Exclusion. First, Providence contends that the Developmental Disability Exclusion is not a "treatment limitation." Providence argues that the Federal Parity Act deals with treatment limitations that are "limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period," or other similar limits comparable to those listed. Providence argues that under the principal of *ejusdem generis*, which means that general words should be interpreted consistently with the specific words they follow, "treatment limitations" is limited to similar quantitative limits like "frequency of treatment, number of visits, days of coverage, days in a waiting period." The Developmental Disability Exclusion is not a numerical or quantitative limitation like those listed in the statute, and therefore, Providence argues, it is not a "treatment limitation." This argument is unpersuasive.

The statute itself and the related regulations explicitly note that the Federal Parity Act applies to both quantitative and nonquantitative limitations. *See* 45 C.F.R. § 146.136(a); 29 C.F.R. § 2590.712(a); *see also* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Policy and Addiction Equity Act of 2008, 75 Fed. Reg. 5410-01, 5413 (Feb. 2, 2010) ("The statute describes the term as including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, *but it is not limited to such types of limits*." (emphasis added)). Moreover, the principal of *ejusdem*

generis normally only comes into play when a general word follows a list of specific words. "The *ejusdem generis* canon applies when a drafter has tacked on a catchall phrase at the end of an enumeration of specifics." Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 199 (2012). In this instance, the statute provides examples of what treatment limitations might be after the term is used. The term "treatment limitations" does not appear as a general term at the end of a list of specifics.

The plain and ordinary meaning of "treatment limitation" includes and encompasses the Developmental Disability Exemption. It is a limitation on the treatment of plan members with developmental disabilities. The regulations bolster this interpretation, because they include "[m]edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative," 29 C.F.R. § 2590.712, as an illustration of what a nonquantitative treatment limitation might be. Providence itself has used an "experimental" exemption and a "medical necessity" exemption in addition to the Developmental Disability Exemption when denying coverage for ABA therapy in the past. Thus, the Developmental Disability Exemption, like an experimental or medical necessity exemption, is a "treatment limitation" within the meaning of the Federal Parity Act.

Providence's second argument is that the Federal Parity Act does not require an insurance plan to cover any particular benefits or conditions, but instead merely requires that if Providence were to choose to cover a particular benefit, then they must cover it with equal restrictions as medical benefits. Plaintiffs respond that although the Federal Parity Act does not require coverage of any particular condition, it does require that any limitation on services of an already covered condition be equally applied to mental health and medical conditions. In other words, Providence would be free under the Federal Parity Act not to cover autism. But after Providence

chooses to cover autism, any limitation on services for autism must be applied with parity. Because Providence does cover autism, it cannot use the Developmental Disability Exclusion to deny coverage of ABA therapy because it is a "separate treatment limitation" that applies only to mental health disorders.

The Developmental Disability Exclusion applies specifically and exclusively to mental health conditions. The Federal Parity Act requires that a plan have "no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." 29 U.S.C. § 1185a(a)(3)(A)(ii). Providence's Developmental Disability Exclusion limits coverage of services "related to developmental disabilities, developmental delays or learning disabilities." Ross Decl. Ex. D at 8, Dkt. 41-4. Thus, Providence's exclusion is overtly applicable only to mental health conditions—specifically developmental disabilities—and does not apply to medical or surgical conditions. The plain text of the Federal Parity Act prohibits "separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." 29 U.S.C. § 1185a(a)(3)(A)(ii). Thus, under the plain text of the statute, Providence's Developmental Disability Exclusion is prohibited.

CONCLUSION

Plaintiffs' motion for partial summary judgment (Dkt. 59) is GRANTED, and Defendant's cross motion (Dkt. 67) is DENIED.

IT IS SO ORDERED.

DATED this 8th day of August, 2014.

/s/ Michael H. Simon
Michael H. Simon
United States District Judge