Senate Committee on Business and Transportation
Paul Terdal, Portland, OR
Please Vote YES on Senate Bill 317
February 4, 2015

Chair Beyer and members of the Committee,

Over the past few years, I have volunteered as a consumer advocate and have assisted well over 100 families with issues related to insurance coverage for autism and other health conditions. I'm not a lawyer – I'm just an everyday consumer and private citizen; I got started after I overturned denials of critical care for my own kids, and other families came to me for help. My advocacy has helped many of these families get access to life-changing treatment for their children. It has also led to the Insurance Division's recent bulletins implementing Oregon's Mental Health Parity law – and to several class action lawsuits in Oregon and Washington when administrative appeals have run into legal roadblocks.

Senate Bill 317 – and its House equivalent, HB2857 – are designed to fix three procedural obstacles that have prevented consumers from getting the benefits that they have paid for.

SB317 reinforces the Insurance Division's *existing* ban on "discretionary clauses"

- "Discretionary Clauses" give the insurer a superior right to interpret their contract and to determine what benefits are due to the consumer
- Oregon's Insurance Division, following NAIC guidance, has prohibited "Discretionary Clauses" for more than 10 years on grounds that they are "inequitable, deceptive, and misleading to consumers" – but some insurers include them anyway
- When they slip past the Insurance Division's form review process, they are legally binding making it difficult for consumers to enforce their contractual rights to insurance coverage
- Insurers have challenged the Insurance Division's authority to enforce this policy without more specific legislation
- Exhibit A shows the Insurance Division form that insurer's must complete to certify that they have no "discretionary clauses"
- Exhibit B provides four different examples of such "discretionary clauses" found in Oregon insurance contracts – despite the existing ban

SB317 requires insurers to affirmatively declare compliance with Oregon's Insurance Code

- Litigation to enforce health insurance contracts is normally heard in federal courts under ERISA, based on the terms of the contract
- In AF v Providence, Providence argued that arguing that jurisdiction of Federal Courts is limited to "the terms of the plan" and cannot "enjoin acts because they violate state laws"
- While U.S. District Court disagreed with Providence, SB317 would make it abundantly clear that state law regulating insurance is a part of the terms of the plan – and thus clearly subject to consideration by federal courts
- Exhibit C includes Providence's argument, and U.S. District Court's response

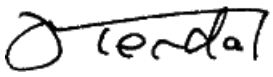
SB317 with -2 amendment provides the Insurance Commissioner with direct enforcement authority for health care benefit mandates

- Chapter 743A mandates health insurance plans to cover specific services and conditions, like mental health conditions or pregnancy and childbirth expenses
- Insurers must certify compliance when filing plans for approval by the Insurance Division – but there isn't a clear enforcement clause if an insurer doesn't provide the required coverage
- -2 amendment makes failure to provide mandated coverage a violation of the unfair claim settlement practices act, providing the Insurance Division with direct enforcement authority

Put in simple terms, SB317 holds insurance companies accountable for dealing with consumers and small businesses fairly. Nothing in this bill should be controversial – it merely reinforces laws and policies that are already in place.

Unfortunately, SB317 *IS* necessary – to plug legal loopholes some insurers have used to evade their contractual obligations to consumers. Please pass SB317 with the -2 amendment.

Sincerely,



Paul Terdal

Attachments:

- Exhibit A: Oregon Form 440-3136B Banning Discretionary Clauses
- Exhibit B: Discretionary Clauses in Oregon Insurance Policies
- Exhibit C: Legal Precedent from AF v Providence on Contract Compliance with Oregon Insurance Code

Exhibit A: Oregon Form 440-3136B Banning Discretionary Clauses

Contents:

- **Form all insurers must certify upon submitting a form for approval by the Insurance Division.** Establishes the following standard:
    - If plan includes a discretionary clause, it does not give the insurer the right to interpret the contract that is legally superior to that of the insured. Discretionary clauses are determined to be prejudicial, unjust, unfair, and inequitable under ORS 742.005(3) and (4). Because such clauses may also reduce an insurer's incentive to draft contracts unambiguously, contracts containing discretionary clauses may also be impermissible under ORS 742.005(2).

Department of Consumer and Business Services
Oregon Insurance Division – 5
350 Winter St. N.E.
P.O. Box 14480
Salem, Oregon 97309
Phone: (503) 947-7983

Standard Provisions for Small Employer Health Benefit Plan
FORM FILINGS

This product standard checklist must be submitted with your filing in compliance with OAR 836-010-0011(2). This list includes national standards, relevant statutes, rules, and other documented positions to enforce ORS 731.016. The standards are summaries and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed. Any line left blank will cause this filing to be considered incomplete. Not including required information or policy provisions may result in disapproval of the filing. (*If submitting your filings electronically, bookmark the provisions in the forms that satisfy the requirement and identify the page/paragraph on this form.*)

Insurer name: _____ **Requested effective date:** _____

TOI (type of insurance):
- ☐ H16G Group Health - Major Medical
- ☐ H15G.003 Group Health – Hospital/Surgical/Medical Expense

Sub-TOI:

☐	H16G.003A	Small Group Only – PPO	☐	H16G.003E	Small Group Only - POS Basic
☐	H16G.003B	Small Group Only - PPO Basic	☐	H16G.003G	Small Group Only - Other (indemnity, EPO, etc.)
☐	H16G.003D	Small Group Only – POS	☐	H15G.003	Small Group Only

Type of group: ☐ Oregon Small Employer (as defined in ORS 743.730)

** Indicates Oregon standard does not apply to Health Care Service Contractors per ORS 750.055, but may be subject to federal standard.*

Category	Reference	Description of review standards requirements	Page and paragraph
Dependent coverage, continued	ORS 743.847(6) Children	An insurer may not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that: (a) The child was born out of wedlock; (b) The child is not claimed as a dependent on the parent's federal tax return; or (c) The child does not reside with the child's parent or in the insurer's service area.	Confirmed ☐
	PHSA 2714, ORS 743A.090(5)(a) Dependents to age 26	Plans that provide dependent coverage must extend coverage to adult children up to age 26. Plans are not required to cover children of adult dependents. *"Child" means an individual who is under 26 years of age.*	Page: Paragraph or Section:
	ORS 106.300 to 340, Bulletin 2008-2 Domestic partners	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined in ORS 106.310 as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Page: Paragraph or Section:
	OAR 105-010-0018 Same-sex marriages performed in other states	Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions. In addition, same-sex married couples validly married in other states now qualify as spouses under COBRA and state continuation.	Confirmed ☐
Discretionary clauses	ORS 742.005(2)(3)(4)	If plan includes a discretionary clause, it does not give the insurer the right to interpret the contract that is legally superior to that of the insured. Discretionary clauses are determined to be prejudicial, unjust, unfair, and inequitable under ORS 742.005(3) and (4). Because such clauses may also reduce an insurer's incentive to draft contracts unambiguously, contracts containing discretionary clauses may also be impermissible under ORS 742.005(2).	Confirmed ☐ N/A ☐
Discrimination	ORS 746.015, OAR 836-080-0055	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.	Confirmed ☐
	ORS 743A.088 Diethylstilbestrol use by mother	Insurers may not deny issuance of a health insurance policy because the mother of the insured used a drug containing diethylstilbestrol prior to the insured's birth.	Confirmed ☐

Exhibit B: Discretionary Clauses in Oregon Insurance Policies

Contents:

- **United Health Care Small Group Plan**
- **PacificSource Group Plan**
- **Kaiser Individual Plan**
- **Providence Group Plan**

Note: all of these plans are fully-insured health benefit plans offered in the State of Oregon. All of these insurers submitted a version of form 440-3136 or equivalent certifying that there were no discretionary clauses.

Our Responsibilities

Determine Benefits

We will determine whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the obligation to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits,* unless the service is excluded in *Section 2: Exclusions and Limitations.* This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to

- You are responsible for contacting PacificSource if you believe you are not receiving adequate care.

PRIVACY AND CONFIDENTIALITY

PacificSource has strict policies in place to protect the confidentiality of your personal information, including your medical records. Your personal information is only available to the PacificSource staff members who need that information to do their jobs.

Disclosure outside PacificSource is allowed only when necessary to provide your coverage, or when otherwise allowed by law. Except when certain statutory exceptions apply, Oregon law requires us to have written authorization from you (or your representative) before disclosing your personal information outside PacificSource. An example of one exception is that we do not need written authorization to disclose information to a designee performing utilization management, quality assurance, or peer review on our behalf.

PLAN ADMINISTRATION

Group Insurance Contract

This plan is fully insured. Benefits are provided under a group insurance contract between your employer and PacificSource Health Plans. Your employer--the policyholder--has a copy of the group insurance contract, which contains specific information regarding eligibility and benefits. Under the insurance contract, PacificSource--not the policyholder--is responsible for paying claims. However, the policyholder and PacificSource share responsibility for administering the plan's eligibility and enrollment requirements. The policyholder has given PacificSource discretionary authority to determine eligibility for benefits under the plan and to interpret the terms of the plan.

If there are any conflicts between this benefit book and the group health contract, the group health contract will govern.

Our address is:

PacificSource Health Plans
PO Box 7068
Eugene OR 97401-0068

Plan Funding

Insurance premiums for employees are paid in whole or in part by the plan sponsor (your employer) out of its general assets. Any portion not paid by the plan sponsor is paid by employee payroll deductions.

Plan Changes

The terms, conditions, and benefits of this plan may be changed from time to time. The following people have the authority to accept or approve changes or terminate this plan:

- The policyholder's board of directors or other governing body
- The owner or partners of the business
- Anyone authorized by the above people to take such action

The plan administrator is authorized to apply for and accept policy changes on behalf of the policyholder.

If changes occur, PacificSource will provide your plan administrator with information to notify you of changes to your plan. Your plan administrator will then communicate any benefit changes to you.

Kaiser

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorneys' fees and other expenses in any dispute.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC*, and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Exercise of Conscience

We recognize the right to exercise religious beliefs and conscience. If a Participating Provider or Participating Facility declines to provide a covered Service for reasons of conscience or religion, we will make arrangements to provide the covered Services.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Oregon law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Company whether or not set forth in this *EOC*.

Litigation Venue

Venue for all litigation between you and Company shall lie in Multnomah County, Oregon.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Membership Services as soon as possible to give us their new address.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

EMPLOYER RECORDS

The Employer is responsible for keeping accurate records relating to this Group Contract. The records must contain all the information Providence Health Plan needs to administer this contract. Providence Health Plan has the right to request, inspect or audit the Employer's records at any reasonable time during regular business hours.

ADMINISTRATION AND INTERPRETATION OF THE PLAN

To the extent this Group Contract relates to an employee benefit plan that is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Employer's responsibilities and Providence Health Plan responsibilities include the following:

- The Employer is responsible for furnishing summary plan descriptions, annual reports and summary annual reports to plan participants and to the government as required by ERISA.
- The Employer and not Providence Health Plan is the "Plan Administrator" as defined in ERISA.
- The Employer is responsible for providing all notices regarding the COBRA continuation provisions specified in section 11.2. Providence Health Plan is responsible for providing all notices of Creditable Coverage, as specified in section 10.4, and notices regarding the availability of State Mandated Continuation Coverage, as specified in section 11.1 and Portability Plans, as specified in section 12, unless the Employer agrees to provide such notices.
- The Employer gives Providence Health Plan, acting for the "Plan Administrator," the discretionary authority to interpret the terms of the related ERISA plan, to make factual determinations relevant to benefit determinations and to otherwise decide all questions regarding eligibility for benefits under the plan.

Benefits shall be payable to a Member under the ERISA plan and this Group Contract only if Providence Health Plan, in its discretion, determines that such benefits are payable. Providence Health Plan's determination regarding the meaning of the provisions of the ERISA plan and this Group Contract shall not be subject to challenge absent a finding that such determination in any particular case is arbitrary and capricious.

LIMIT OF LIABILITY WHEN INACCURATE DESCRIPTIVE MATERIALS ARE DEVELOPED BY EMPLOYER

The Employer will indemnify, defend and hold Providence Health Plan harmless from any claims, damages, judgments and expenses (including attorney's fees) based on or arising out of, directly or indirectly, descriptive materials written, created, designed or printed by the Employer, or on the Employer's behalf by any third party when such descriptive materials:

1. Are used without prior review and written approval by us; and
2. Inaccurately reflect any of the terms, conditions and/or provisions of this Group Contract.

The term "descriptive materials" includes, without limitation, any type of circular, leaflet, booklet, summary, handbook, letter or form that describes in whole or in part any of the terms, conditions and/or provisions of this Group Contract.

Exhibit C: Legal Precedent from AF v Providence on Contract Compliance with Oregon Insurance Code

Contents:

- **Memorandum from Providence** arguing that jurisdiction of Federal Courts is limited to "the terms of the plan" and cannot "enjoin acts because they violate state laws"
- **Decision from U.S. District Court** that ERISA provides courts with the power to enjoin violations of state law because "it is a general principle of insurance law" that state law supercedes conflicting policy provisions

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Of Attorneys for Defendant Providence Health Plan

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

PORTLAND DIVISION

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,

vs.

PROVIDENCE HEALTH PLAN,

Defendant.

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

DEFENDANT'S MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR JUDGMENT ON THE PLEADINGS, FOR DECLARATORY RELIEF AND FOR A PERMANENT INJUNCTION AND IN SUPPORT OF DEFENDANT'S FIRST MOTION FOR SUMMARY JUDGMENT

II. THERE IS NO CIVIL ACTION PROVIDED BY ERISA § 502(a)(3) BY WHICH THIS COURT IS EMPOWERED TO DECIDE THAT THE TERMS OF AN ERISA PLAN VIOLATE STATE LAW.

As described above, plaintiffs in this action seek a ruling, under ERISA § 502(a)(3), that Providence's denial of coverage for ABA services under the Exclusion was contrary to two state laws, ORS 743A.168 and ORS 743A.190, and to one federal law. Complaint ¶ 131. The threshold problem is that, as to the question whether Providence's exclusion violates Oregon state law, § 502(a)(3) provides no basis for plaintiffs to litigate their claim in federal court.

ERISA § 502(a)(3) provides as follows:

> (a) Persons empowered to bring a civil action. A civil action may be brought –
>
> … (3) 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). Stated more simply, under subsection (a)(3), the court has jurisdiction to enjoin acts that are contrary to "any provision of [ERISA]" or "the terms of the plan." In contrast, subsection (a)(3) does not provide a cause of action to enjoin acts because they are contrary to *state laws*.

For example, in *Haviland v. Metropolitan Life Ins. Co.*, 876 F. Supp. 2d 946 (E.D. Mich. 2012), *aff'd,* 730 F.3d 563 (6th Cir. 2013), *petition for certiorari filed* (Jan. 21, 2014 (No. 13-905)), plaintiffs sought a declaration that an insurer could not reduce benefits below a certain level because of a Michigan statute that regulates notice of the termination of insurance coverage. The plaintiff in *Haviland* pleaded precisely the type of claim that plaintiffs in this action have pleaded (and on which they now have moved for judgment on the pleadings): he asserted a § 502(a)(3) action seeking a ruling that his insurer's act was contrary to state law.

In concluding that the claim was subject to dismissal, the court explained:

> ERISA §502(a)(3) does not apply here. **A plaintiff cannot seek a declaration under ERISA that certain alleged actions violate state law** because the plaintiff is not seeking "(A) to enjoin any act or practice which violates any provision of this title or the terms of the plan" or "(B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this title or the terms of the plan."

Haviland, 876 F. Supp. 2d at 963-64 (emphasis added). The same result obtains here.

Plaintiffs recognize, as they must, that the terms of subsection (a)(3) permit the Court to enjoin only those practices that violate either ERISA or the plan itself, not practices that violate state law. Plaintiffs' explanation in response is simply to postulate that violations of state law *are by definition* violations of ERISA itself, stating, "[B]ecause *ERISA requires insurers to follow state laws*, violations of … Oregon state laws constitute ERISA violations." Plaintiffs' Memo at 2 n.3 (emphasis added).

But plaintiffs are simply incorrect. There is no provision in ERISA that requires health plans to follow state laws or that makes violations of state law into "ERISA violations," and plaintiffs cite none. On the contrary, ERISA preempts state laws, with limited exceptions, including an exception for "any law of any State which regulates insurance." 29 U.S.C. § 1144(a)-(b). That ERISA does not preempt applicable "insurance" laws, however, does not mean that ERISA makes a violation of such laws into a federal matter. It only means that state law may operate, to that extent, on matters relating to a plan. Plaintiffs, in contrast, are inviting the Court to preempt the terms of an ERISA plan by using state law, turning § 502(a)(3) entirely on its head by claiming that statute as a basis to invalidate the terms of a plan, rather than as a basis to enforce the plan terms.

To be sure, Providence has duties to comply with Oregon law. But they do not stem from ERISA, and do not transform state law violations into violations of ERISA itself. As the court found in *Haviland*, § 502(a)(3) does not therefore give this Court a basis to decide whether

Providence's actions violate state laws such as ORS 743A.168 or ORS 743A.190.

Whether or not any alternate basis might exist upon which to state a federal claim to decide those state law questions is not properly before this Court on plaintiffs' motion. Plaintiffs have moved for judgment "on the pleadings," and their First Claim for Relief relies solely on ERISA as the basis for their First Claim for Relief. Complaint ¶ 131. Moreover, plaintiffs have identified only 28 U.S.C. § 1331 (federal question jurisdiction) and 28 U.S.C. §§ 1711-1715 (class actions), in addition to ERISA, as bases for this Court's subject matter jurisdiction. Complaint ¶ 5. Section 1331 gives federal courts the power to adjudicate claims "arising under the Constitution, laws, or treaties of the United States," not claims arising under state law, and sections 1711-1715 are not bases for subject matter jurisdiction at all, much less a basis for federal courts to entertain state claims. Plaintiffs' motion must, therefore, be denied as to their state law contentions.

III. THE EXCLUSION DOES NOT VIOLATE ORS 743A.168.

Assuming *arguendo* that plaintiffs had pleaded a valid claim under ERISA upon which to invalidate the Exclusion, plaintiffs are also wrong on the merits of their state claims. ORS 743A.168 is the first state statute that plaintiffs claim to obligate Providence to cover ABA services. Providence's denial of ABA services based on the Exclusion, however, has not violated that statute in any way.

As a preliminary matter, plaintiffs' motion addresses that question by conflating two different questions. The first is the narrow, treatment-specific question of whether ORS 743A.168 requires that plans cover ABA services in particular for treatment of ASD, making Providence's denial of that service unlawful regardless of its claimed exclusion. The second is the broader and more far-reaching question of whether ORS 743A.168 makes the Exclusion itself illegal, regardless of the service in question – such that Oregon law prohibits any health plan from excluding any services "related to developmental disabilities, developmental delays or

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,

> 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.