May 19, 2015

Paul Terdal
NW Portland (HD36 / SD18)

Chairs Sen. Bates and Rep. Nathanson,
Joint Ways and Means Subcommittee on Human Services
900 Court St. NE
Salem, OR 97301

**Re: SB696A / SB365 Is not a "New" Mandate – Oregon's Mental Health Parity Legislative History**

Dear Chairs Sen. Bates and Rep. Nathanson, and Members of the Committee,

This is to provide supplemental information on the fiscal impact of SB696A.

SB696A is a revision to the 2013 SB365, which established the Behavior Analysis Regulatory Board to license and register providers of Applied Behavior Analysis (ABA) services, and described a structure to facilitate insurer management of claims for coverage of medically necessary treatment of autism spectrum disorder, including ABA.

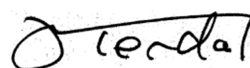
SB365 did not, however, create a new insurance mandate for treatment of autism: ORS 743A.168, Oregon's Mental Health Parity law, enacted as SB1 in 2005; and ORS 743A.190, Children with Pervasive Developmental Disorder, enacted as HB2918 in 2007, both already mandated coverage of treatment for autism. This is significant, because under the Federal Patient Protection and Affordable Care Act, the State of Oregon could have been liable for the cost of new mandates that went beyond Oregon's "Essential Health Benefits Package," as was discussed in the Fiscal Impact Analysis for SB365.

In testimony on SB696 submitted to the Senate Health Care committee on 4/8/2015, I provided copies of a legal decision in "AF v Providence," and findings by the Oregon Insurance Division and Department of Justice which established that Oregon's Mental Health Parity law already mandated more substantial coverage of Applied Behavior Analysis and other therapies for autism than described in SB365 – confirming that, indeed, SB365 wasn't a "new" mandate for coverage of treatment for autism. (https://olis.leg.state.or.us/liz/2015R1/Downloads/CommitteeMeetingDocument/61627)

This ensures that the state won't be liable for the cost of this coverage under the Affordable Care Act.

For reference, this letter includes an outline of prior Oregon Mental Health Parity / Autism Legislation – reiterating that Oregon law has mandated coverage of treatment for autism and other mental health conditions for many, many years.

Sincerely,



Paul Terdal

## Appendix: Outline of Oregon Mental Health Parity / Autism Legislation

1. For more than twenty years Oregon has mandated that group health insurance policies include coverage for expenses arising from treatment for mental or nervous conditions. Testimony of Scott Kipper, September 16, 2008 (Exhibit A at page 2), Testimony of Teresa Miller, June 4, 2009 (Exhibit B at page 1), and 2009 Review of Coverage of Mental or Nervous Conditions and Chemical Dependency (Exhibit C at page 2). The 1989 version of ORS 743.556, now ORS 743A.168, states: "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."

2. Jim Swenson, Administrator for the Oregon Insurance Division, testified that "ORS 743.556 mandates that Oregon-based health insurance policies provide coverage for mental health services requiring they be subject to the same co-insurance and deductibles as other medical services, although they are subject to some internal limits." (Exhibit D at page 3)

3. That Oregon law has long mandated coverage for treatment of mental or nervous conditions should be well known in the insurance industry. Indeed, an "Analysis of Group Health Insurance Mandates Required By The Oregon Insurance Code," authored by the Oregon Insurance Pool Governing Board on March 12, 2004, states that ORS 743.556 is a "benefit mandate" and requires coverage of expenses arising from treatment for mental or nervous conditions. (Exhibit E at page 5) The Oregon Psychological Association noted the mandate in its testimony to the Oregon Legislative Assembly on May 20, 2005. (Exhibit F at page 1)

4. Prior to 2007, the coverage mandate for treatment for mental or nervous conditions was subject to numerous limitations. For example, the statute allowed a benefit limitation of $13,125 for adults and $15,625 for children. *See* ORS 743.556 (10). Senate Bill 1 was introduced in the 2005 Regular Session of the Oregon Legislative Assembly to address these limitations.

5. Senate Bill 1 is commonly referred to as the Oregon Mental Health Parity Act. As originally proposed and as adopted, Senate Bill 1 did not eliminate any preexisting coverage mandates.

6. Senate Bill 1 prohibits group health insurers from imposing financial or treatment limitations for mental health and chemical dependency treatment services unless similar limitations are imposed on coverage of other medical conditions. Written testimony of Oregon Senate President Peter Courtney, March 9, 2005 (Exhibit G) and written testimony of Oregon Department of Human Services Health Services Administrator Robert Nikkel March 9, 2005, (Exhibit H).

7. Senate Bill 1 requires that health insurance coverage for the treatment of mental health or nervous conditions and chemical dependency be in parity with other medical coverage. According to Oregon's insurance regulator, the Department of Consumer and Business Services, Insurance Division: "The legislation requires that group health insurance policies provide treatment benefits for chemical dependency and for mental or nervous conditions at the same level and subject to limitations no more restrictive than those imposed for treatment of other medical conditions." 2009 Review of Coverage of Mental or Nervous Conditions and Chemical Dependency (Exhibit C at p. 1).

8. The OMHPA, Senate Bill 1, became effective on January 1, 2007 and is now codified at ORS 743A.168.

9. The “mental or nervous conditions” that are required to be covered by ORS 743A.168 are defined in OAR 836-053-1404 as “All disorders listed in the ‘Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition, except for” certain specified diagnostic codes.

10. The diagnostic codes excluded from the definition of “mental or nervous conditions” in OAR 836-053-1404 do not include the diagnostic code for autism, 299.00. That means that autism is included in the mental or nervous conditions that are required to be covered by ORS 743A.168.

11. U.S. Judge Janice Stewart ruled in the *McHenry* case Oregon law contained a mental health mandate, stating that :

> “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.” (Exhibit I).

## Exhibits:

- Exhibit A: Scott Kipper, Administrator of Oregon Insurance Division, to House Health Care, 9/16/2008, on SB1 (2005)
- Exhibit B: Teresa Miller, Acting Administrator of Oregon Insurance Division, to House Health Care, 6/5/2009, on SB1 (2005)
- Exhibit C: 2009 Review of Coverage of Mental or Nervous Conditions and Chemical Dependency
- Exhibit D: Jim Swenson, Administrator for the Oregon Insurance Division, to House Committee on Business and Consumer Affairs, 1/31/1991
- Exhibit E: Analysis of Group Health Insurance Mandates, Oregon Insurance Pool Governing Board, 3/12/2004
- Exhibit F: Dr. Robert Lundblad, Oregon Psychological Association, Testimony to House Health Care, 5/20/2005
- Exhibit G: Senate President Peter Courtney, Testimony to Senate Committee on Health Policy, on SB1, 3/9/2005
- Exhibit H: Robert Nikkel, Administrator Health Sevices, Office of Mental Health and Addiction Services, to Senate Health Policy Committee, on SB1, 3/9/2005
- Exhibit I: McHenry v PacificSource, Opinions by Judge Janice Stewart, Case 3:08-cv-00562-ST, 1/5/2010, 4/26/2010, 9/28/2010, 8/30/2011

**Department of Consumer and Business Services**
350 Winter Street NE, Room 200
P.O. Box 14480
Salem, Oregon 97309-0405
(503) 947-7872
www.cbs.state.or.us

Before the
House Interim Committee on Health Care

September 16, 2008

**Senate Bill 1 (2005)**

Testimony of
Scott Kipper, Administrator
Insurance Division
Department of Consumer and Business Services

Chair Greenlick, members of the committee, my name is Scott Kipper. I am the Administrator of the Insurance Division of the Department of Consumer and Business Services (DCBS). I am here today to discuss Senate Bill 1 enacted during the 2005 legislative session. Senate Bill 1 requires that health insurance coverage for the treatment of mental health or nervous conditions and chemical dependency be in parity with other medical coverage. The bill was enacted in part to end the disparity in insurance coverage for psychiatry and medicine and to unify treatment of the whole person - mind and body.

The legislation requires that group health insurance policies provide treatment benefits for chemical dependency and for mental or nervous conditions at the same level and subject to limitations no more restrictive than those imposed for treatment of other medical conditions. The legislation prohibits specific visit limits for mental health treatment not required for other medical conditions and eliminates differences in co-payments, coinsurance, deductibles, maximum out of pocket expenses and lifetime maximum benefits for chemical dependency and mental health or nervous condition treatments that were previously permitted.

**Background**

Oregon has required mental health benefits for group insurance plans since 1975. In 1987 Oregon combined mental health and chemical dependency coverage laws and established separate dollar limits for adults and children. By 1998, all insurers offering group health benefit plans used durational limits, thereby limiting the number of mental health visits they covered. In 1999, Oregon increased the minimum dollar coverage requirements by 25%. After this increase, chemical dependency treatment and mental health care were required for a number of visits that equaled $13,125 for adults and $15,625 for children under 18 years old. Until passage of SB 1, insurers were permitted to carve out and not cover

mental health prescription medications even when prescriptions were covered for other medical conditions.

Senate Bill 1, codified at ORS 743A.168, was passed by the 2005 Oregon Legislature and became effective January 1, 2007 or the first policy renewal date thereafter. In passing Senate Bill 1, Oregon joined 32 other states that enacted mental health parity laws and 14 additional states that expanded mental health coverage.

Before examining the effects of the legislation, let me first set the context by defining terms, exclusions, and talking about the types of health insurance that must comply with the new law.

**Exclusions**

ORS 743A.168 does not apply to all types of health insurance. Individual health plans, self-insured employer group health plans, disease specific insurance plans, long term care plans, disability plans, Medicare, and Medicaid are not required to comply.

ORS 743A.168 (4) (a) does not apply to all services. Educational and correctional services, long term residential mental health treatment lasting longer than 45 days, psychoanalysis or psychotherapy received as part of an educational or training program, court ordered sex offender, and court-ordered DUII screening and treatment are excluded. ORS 743A.168 (6)

excludes reimbursement for support groups and ORS 743A.168 (7) permits insurers to limit coverage for in-home services.

**Application of the Law**

**Reimbursement.** Senate Bill 1 specifies that a provider is eligible for reimbursement for the treatment of mental health, nervous conditions and chemical dependency if the provider is approved by the Department of Human Services, is accredited, and provides a covered benefit under the health insurance policy. Eligible providers include health care facilities, residential programs or facilities, day or partial hospitalization programs, outpatient services, inpatient services, and licensed providers practicing within the scope of their licenses.

**Policy Provisions.** The law does not specify the amount of reimbursement for treatment. Rather, coverage for chemical dependency and mental or nervous conditions is subject to the provisions of the policy that apply to other benefits including medical necessity, deductibles, copayment, coinsurance, reimbursement, and treatment limitations.

**Management tools.** Senate Bill 1 does not prohibit insurers from managing benefits for mental health, nervous conditions and chemical dependency through common methods such as prior authorization, which requires that the insurer authorize treatment before it is provided, and

utilization review, which allows the insurer to review the medical necessity, use, and efficacy of the treatment as long as those requirements are imposed on the coverage for other medical conditions.

**Implementation**

After passage of the new law, the Insurance Division worked with consumer groups and stakeholders and held several trainings and discussion groups to work on transition and implementation. In addition to the trainings and discussion groups, the Insurance Division hosted multi-stakeholder advisory meetings to seek input on the development of Oregon Administrative Rules to help implement the law. Insurers, providers, consumers, the Department of Human Services, and the National Alliance on Mental Illness (NAMI) representatives among others, participated in discussions used to draft and shape the Division's rules.

**Assessment of Implementation**

Since implementation of the law on January 1, 2007, the Insurance Division has monitored compliance and resolved complaints. We are not seeing significant consumer complaint activity related to Senate Bill 1 and mental health parity. The Division has completed investigations and closed 51 complaint files. 49 of these files did not involve violations of Senate Bill 1, because they were either (a) filed by consumers with individual or self-

insured plans, which are not subject to the requirements of the law (11 complaints); (b) made for services received prior to the effective date of the law (8 complaints); (c) related to administrative issues, poor customer service, delays in payment, incorrect identification numbers, or claims misinformation (12 complaints); or (d) related to denials due to lack of medical necessity, lack of coverage under the plan, or because services were obtained from out-of-network providers (18 complaints). Under SB 1, insurers may deny or limit coverage for these reasons.

In the two Consumer Advocacy cases where violations of Senate Bill 1 were found, contractual language specifically limiting coverage for developmental disorders and mental health and chemical dependency treatment was identified. The Division required the companies to remove the offending language and to comply with the mandates of Senate Bill 1.

Through our Market Analysis Unit, the unit of the Division that gathers data and conducts in-depth investigations into potential violations of the Insurance Code, we looked into insurers' uses of utilization review, treatment plan requirements, and contract language. We have also reviewed the mental health, nervous conditions, and chemical dependency treatment policies and procedures of 14 insurers. The Division found contract language in violation of Senate Bill 1, and as a result, we are

currently working to bring carriers into compliance with the mandates of Senate Bill 1. We are also in the process of drafting and issuing a bulletin further explaining the requirements of the bill.

**Cost-Benefit Estimates: claims & cost**

The Congressional Budget Office and private actuarial firms estimated the impact of parity on health insurance premiums and reported rate increases ranging from 3.2% to 11.4%. The expected average increase in Oregon health insurance premium rates was estimated at 1.5%. During the latest round of rate filings, three carriers estimated the effects of the law on rates. According to the information filed by these carriers, Senate Bill 1 has caused rate increases, ranging from one-half of one percent to approximately two percent.

While we have no verified data on the impact of Senate Bill 1 at this time, we are in the process of preparing a data call to health insurers requesting claims and expenditure information about mental health, nervous conditions, and chemical dependency treatment. We expect to be able to report results from the data call by February of 2009. Once compiled and analyzed, the data should show by how much mental health claims, nervous disorder claims, and/or chemical dependence claims have increased or decreased since the passage of Senate Bill 1 on a per

member per month basis. The data should also show the number of in and out of network claims, pharmacy claims, long-term (45 days or more) residential mental health care claims, psychotherapy claims, in and out patient claims, residential treatment claims and the cost for each.

June 5, 2009

To: House Health Care Committee

From: Teresa Miller, Acting Administrator, Insurance Division

Subject: Senate Bill 1 (2005 Session), Mental Health Parity Data Call Report

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Senate Bill 1 requires that group health insurance policies provide treatment benefits for chemical dependency and for mental or nervous conditions at the same level and subject to limitations no more restrictive than those imposed for treatment of other medical conditions. The legislation prohibits specific visit limits for mental health treatment not required for other medical conditions and eliminates differences in co-payments, coinsurance, deductibles, maximum out of pocket expenses, and lifetime maximum benefits for chemical dependency and mental health or nervous condition treatments that were previously permitted.

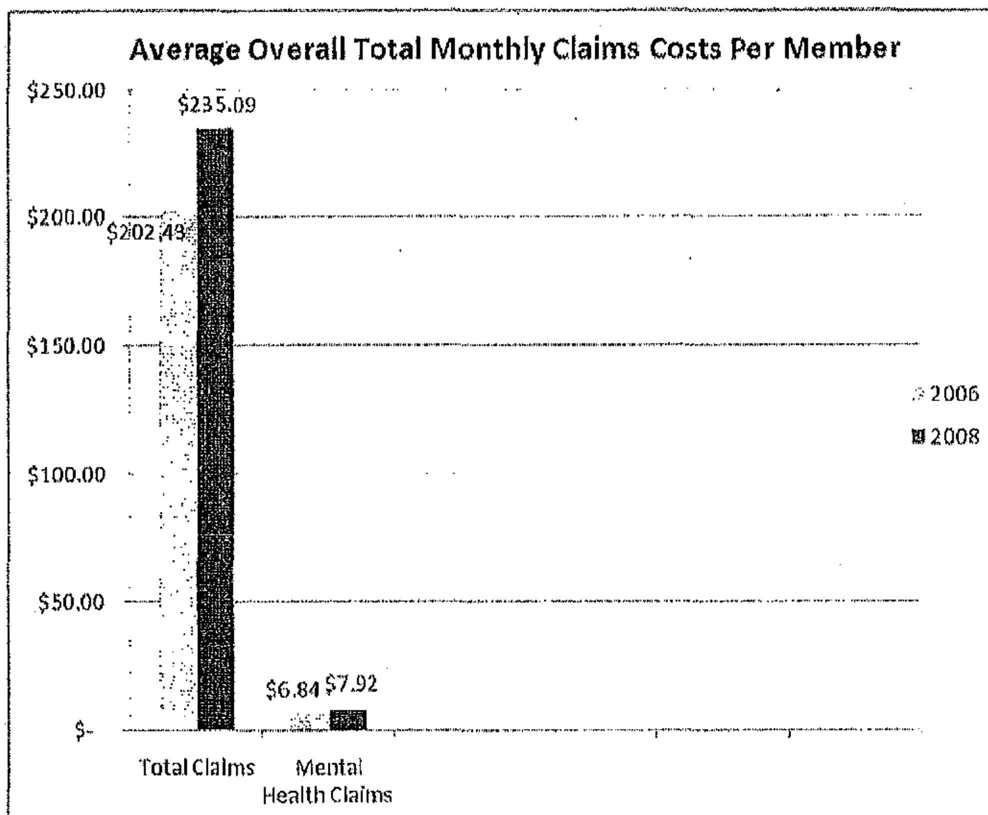
Oregon has required mental health benefits for group insurance plans since 1975. In 1987, Oregon combined mental health and chemical dependency coverage laws and established separate dollar limits for adults and children. By 1998, all insurers offering group health benefit plans used durational limits, thereby limiting the number of mental health visits they covered. In 1999, Oregon increased the minimum dollar coverage requirements by 25%. After this increase, chemical dependency treatment and mental health care were required for a number of visits that equaled $13,125 for adults and $15,625 for children under 18 years old. Until passage of Senate Bill 1, insurers were permitted to carve out and not cover mental health prescription medications even when prescriptions were covered for other medical conditions.

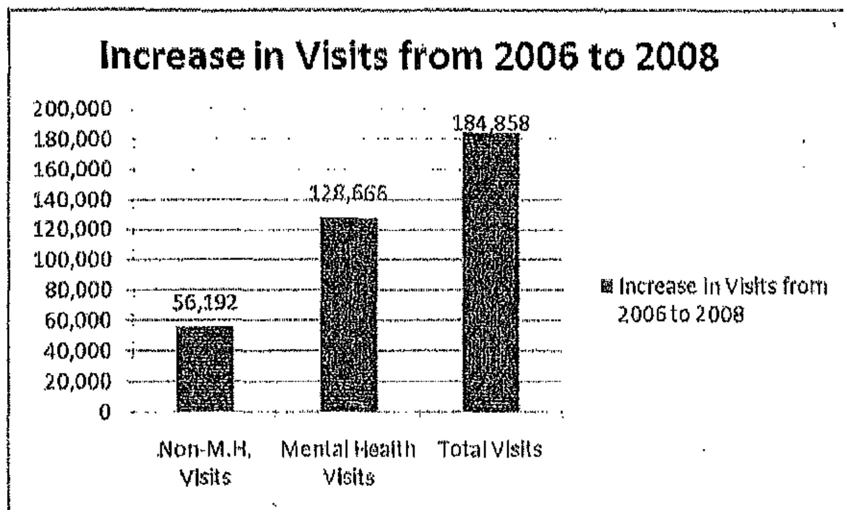
Senate Bill 1, codified at ORS 743A.168, was passed by the 2005 Oregon Legislative Assembly and became effective January 1, 2007 or the first policy renewal date thereafter. In passing Senate Bill 1, Oregon joined 32 other states that have enacted mental health parity laws and 14 additional states that have expanded mental health coverage.

On September 16, 2008, the Insurance Division of the Department of Consumer and Business Services testified before the House Interim Committee on Health Care regarding Senate Bill 1. The Committee expressed interest in the impact of mental health parity on insurance rates. At the time the Division presented its testimony, we were in the process of collecting mental health claims, chemical dependency claims, and overall claims cost data from ten of the larger insurers that write health insurance in Oregon. The data we collected compares 2006 claims, those made before Senate Bill 1 took effect, with 2008 claims, claims made after the effective date of the

legislation. Pharmacy benefits were not included in the data we collected, and the effect of other factors such as medical inflation, changes in patient demographics, and changes in environment such as local economic conditions were not quantified. These and other factors could impact the data discussed in this report.

In summary, the data collected by the Insurance Division of the Department of Consumer and Business Services show that while the number of mental health and chemical dependency (collectively "mental health" unless noted otherwise) visits has increased significantly from 2006 to 2008, accounting for nearly 70% of the increase in total healthcare visits, there appears to be relatively little impact to total healthcare claims costs. From 2006 to 2008, the average overall total monthly amount paid by insurers and insureds for all claims, including both medical claims and mental health claims, per member increased from $202.43 to $235.09, a total difference of $32.66 or approximately 16%. Mental health claims costs rose an average of $1.08 per month during this same period, which is approximately 3% of the total increase in the overall monthly cost for all claims. The graph below depicts the changes in monthly claims costs for total claims and mental health claims from 2006 to 2008.





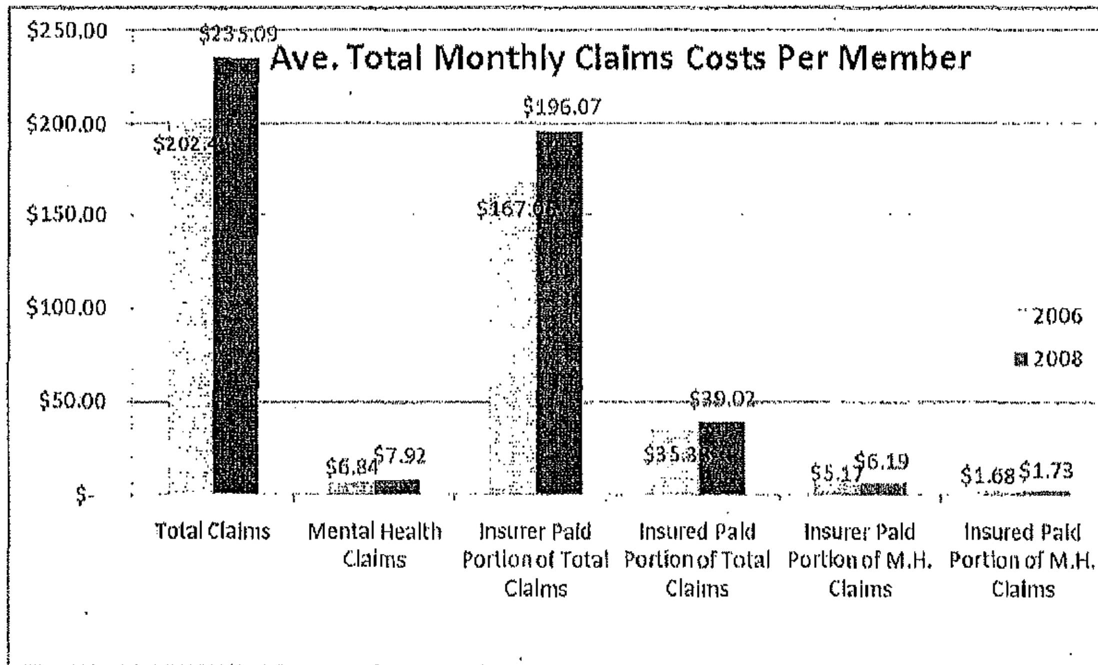

As the graph above demonstrates, the number of mental health visits increased by 128,666, or approximately 16% from 2006 to 2008. Despite this increase, mental health costs remained at a constant 3.4% of total healthcare claims costs. The fact that mental health and chemical dependency claims remained consistent from 2006 to 2008 may suggest that Senate Bill 1 has not had a significant impact on overall health insurance claims expenses. However, this may simply result from the fact that the increase in the cost of mental health and chemical dependency claims is small monetarily and that these claims represent only a relatively small percentage of total healthcare claims costs. Consequently, year to year fluctuations may bear little relationship to long-term cost drivers.

In conclusion, although the data may suggest that Senate Bill 1 has had a significant impact on increased access to mental health and chemical dependency care without having much of an impact on costs, whether and to what extent this increase in access is directly attributable to Senate Bill 1 is unknown. The data collected and reviewed in this report can be subject to varying interpretations, and whether the short-term trends suggested by the data will continue in the long-term remains to be seen.[1] The Insurance Division of the Department of Consumer and Business Services welcomes additional review of, and comment on, the data.

[1] A more detailed discussion of the data as well as several tables comparing additional data collected by the Insurance Division can be found in the attached appendix. These comparisons include the average claim amounts paid per visit by treatment type, the shares paid by the insured by claim type, the percent of visits by claim type, the frequency of visits per member per month by claim type, and more.

# Appendix to Senate Bill 1 Report[2]

From 2006 to 2008, the average overall total monthly amount paid by insurers and insureds for all claims, including both medical claims and mental health claims, per member increased from $202.43 to $235.09, a total difference of $32.66 or approximately 16%. Of the monthly average total paid in 2008, insurers paid $196.07, an increase of $29.02 or approximately 17% from 2006, while insureds paid $39.02, an average monthly increase of $3.64, or approximately 10% from 2006. From 2006 to 2008, the total average monthly costs paid for mental health claims rose from $6.84 to $7.92, an increase of $1.08, or 16%.[3] The increase in the cost of mental health claims amounts to approximately 3% of the total increase in the overall monthly cost for all claims. Of the total mental health costs paid in 2008, insurers paid an average of $6.19 per member per month, an increase of $1.02, or approximately 20% from 2006, while insureds paid an average of $1.73 per month, an increase of $.05, or approximately 3% from 2006. The graph below depicts the change in overall total monthly amounts paid by insurers and insureds for claims from 2006 to 2008.




[2] Percentages found in the text are rounded to the nearest whole number or tenth of a percent.
[3] From 2006 to 2008, total average monthly chemical dependency claims costs decreased from $1.48 to $1.36, an average decrease of $.12, or approximately 8%.

In both 2006 and 2008, mental health claims accounted for approximately 3.1% of the total cost of insurers' healthcare claims. In 2006, these claims accounted for 4.7% of the total cost of insureds' healthcare claims, and in 2008, these claims accounted for 4.4% of the total cost of patients' healthcare claims. Despite the increases in the cost of mental health claims noted in the paragraph above, the fact that mental health and chemical dependency claims remained consistent relative to total healthcare claims costs may suggest that Senate Bill 1 has not had a significant impact on overall health insurance claims expenses. However, drawing such a conclusion may be unwarranted, because mental health and chemical dependency claims comprise only a small part of overall healthcare claims costs. As a result, year to year fluctuations may bear little relationship to long term cost drivers.

Table I below shows the change in the number of visits by claim type. From 2006 to 2008, total claim visits for all treatments (medical, mental health, chemical dependency, etc.) rose by 184,458, an increase of 1.8%. Mental health and chemical dependency visits (128,666) comprise nearly 70% of this increase. Although the data might suggest that Senate Bill 1 has had a significant impact on increased access to mental health and chemical dependency care, whether and/or to what extent this increase in visits is directly attributable to Senate Bill 1 is unknown.

**Table I – Number of visits by claim type**

| Year | Mental health | Chemical Dependency | Total Claims |
|---|---|---|---|
| 2006 | 601,935 | 73,641 | 10,347,330 |
| 2008 | 709,492 | 94,750 | 10,531,788 |
| Change | 107,557 | 21,109 | 184,458 |
| %Change from 2006 to 2008 | 17.9% | 28.7% | 1.8% |
| % of Total Change | 58.3% | 11.4% | N/A |

Table II below shows the number of visits by facility for inpatient mental health (treatment for fewer than 45 days), residential mental health (treatment for 45 days or more), and residential chemical dependency treatment (treatment for 45 days or more) claims. While the number of inpatient mental health claims decreased by 6.2% and the number of residential mental health claims decreased by 30%, the number of residential chemical dependency claims increased by 70%. These significant differences in utilization statistics are interesting; however, they indicate that there is no readily determinable trend apparent in the data.

**Table II – No. of Visits by Facility**

| Year | Inpatient MH | Resident MH | Resident Chem Dep |
|---|---|---|---|
| 2006 | 5,999 | 33,330 | 4,869 |
| 2008 | 5,629 | 23,360 | 8,257 |
| Change | (370) | (9,970) | 3,388 |
| Percent Change | -6.2% | -29.9% | 69.6% |

In conclusion, the data collected by the Insurance Division of the Department of Consumer and Business Services show that while the number of mental health and chemical dependency visits has increased significantly from 2006 to 2008, accounting for nearly 70% of the increase in total healthcare visits, there appears to be relatively little impact to total healthcare claims costs. Mental health costs remained at a little over 3.1% of insurers' total healthcare claims costs, and insureds actually saw a small decrease in the relative percentage of overall costs attributable to mental health claims. This may result from the fact that the increase in the cost of mental health and chemical dependency claims is small monetarily and that these claims represent only a relatively small percentage of total healthcare cost claims. Whether the short-term trends suggested by the data will continue in the long-term remains to be seen.

## SB 1 Data Call - Claims and Visits

**I. Average overall monthly paid per member**

| | Mental Health | | | Chemical Dependency | | | All Claims | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | insurer | insured | total | insurer | insured | total | insurer | insured | total |
| 2006 | 4.03 | 1.33 | 5.36 | 1.15 | 0.33 | 1.48 | 167.05 | 35.38 | 202.43 |
| 2008 | 5.14 | 1.42 | 6.56 | 1.05 | 0.31 | 1.36 | 196.07 | 39.02 | 235.09 |
| Change | 1.11 | 0.09 | 1.20 | (0.10) | (0.02) | (0.12) | 29.02 | 3.64 | 32.66 |
| Percent Change | 27.5% | 6.8% | 22.4% | -8.7% | -6.1% | -8.1% | 17.4% | 10.3% | 16.1% |

**II. Relative share of total claims paid**

| | Mental Health | | | Chemical Dependency | | | Mental Health & Chemical Dep | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | insurer | insured | overall | insurer | insured | overall | insurer | insured | overall |
| 2006 | 2.4% | 3.8% | 2.6% | 0.7% | 0.9% | 0.7% | 3.1% | 4.7% | 3.4% |
| 2008 | 2.6% | 3.6% | 2.8% | 0.5% | 0.8% | 0.6% | 3.1% | 4.4% | 3.4% |
| Percent Change | 0.2% | -0.2% | 0.2% | -0.2% | -0.1% | -0.1% | 0.0% | -0.3% | 0.0% |

**III. Patient Share by Claim Type**

| Year | Mental Health | Chemical Dependency | All Claims |
|---|---|---|---|
| 2006 | 24.8% | 22.3% | 17.5% |
| 2008 | 21.6% | 22.8% | 16.6% |
| Percent Change | -3.2% | 0.5% | -0.9% |

**IV. Average paid claim amount per visit**

| Year | Mental Health | | | Chemical Dependency | | | All Claims | | |
|---|---|---|---|---|---|---|---|---|---|
| | insurer | insured | total | insurer | insured | total | insurer | insured | total |
| 2006 | 110.48 | 36.49 | 146.97 | 258.83 | 73.68 | 332.51 | 266.49 | 56.45 | 322.94 |
| 2008 | 120.31 | 33.26 | 153.56 | 183.73 | 53.94 | 237.67 | 309.26 | 61.55 | 370.81 |
| Change | 9.83 | (3.23) | 6.60 | (75.10) | (19.74) | (94.84) | 42.77 | 5.10 | 47.87 |
| Percent Change | 8.9% | -8.9% | 4.5% | -29.0% | -26.8% | -28.5% | 16.0% | 9.0% | 14.8% |

**V. Number of visits by claim type**

| Year | mental health | Chemical Dependency | Total Claims |
|---|---|---|---|
| 2006 | 601,935 | 73,641 | 10,347,330 |
| 2008 | 709,492 | 94,750 | 10,531,788 |
| Change | 107,557 | 21,109 | 184,458 |
| %Change from 2006 to 2008 | 17.9% | 28.7% | 1.8% |
| Percent Change from Total | 58.3% | 11.4% | N/A |

**VI. Frequency - visits per member month**

| Year | mental health | Chemical Dependency | Total Claims |
|---|---|---|---|
| 2006 | 3.6% | 0.4% | 62.7% |
| 2008 | 4.3% | 0.6% | 63.4% |
| Difference | 0.7% | 0.2% | 0.7% |

**VII. Percent of visits by claim type**

| Year | mental health | Chemical Dependency |
|---|---|---|
| 2006 | 5.8% | 0.7% |
| 2008 | 6.7% | 0.9% |
| Difference | 0.9% | 0.2% |

# SB1 Data Call - Inpatient and Residential Mental Health and Res. Chem. Dependency

## I. Average monthly paid per member

| | Inpatient Mental Health | | | Residential Mental Health | | | Residential Chemical Dependency | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | insurer | insured | total | insurer | insured | total | insurer | insured | total |
| 2006 | 0.80 | 0.12 | 0.93 | 0.35 | 0.15 | 0.51 | 0.32 | 0.07 | 0.39 |
| 2008 | 1.00 | 0.14 | 1.14 | 0.31 | 0.09 | 0.39 | 0.48 | 0.11 | 0.59 |
| Change | 0.20 | 0.02 | 0.21 | (0.04) | (0.06) | (0.10) | 0.16 | 0.04 | 0.20 |
| % Change | 25.0% | 16.7% | 22.6% | -11.4% | -40.0% | -20.0% | 50.0% | 57.1% | 51.3% |

## II. Share of Total Claims Paid

| | Inpatient Mental Health | | | Residential Mental Health | | | Residential Chemical Dependency | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | insurer | insured | total | insurer | insured | total | insurer | insured | total |
| 2006 | 0.48% | 0.35% | 0.83% | 0.21% | 0.44% | 0.65% | 0.19% | 0.19% | 0.38% |
| 2008 | 0.51% | 0.35% | 0.86% | 0.16% | 0.22% | 0.38% | 0.24% | 0.27% | 0.51% |
| % Change | 0.03% | 0.0% | 0.03% | -0.05% | -0.22% | -0.27% | 0.05% | 0.08% | 0.13% |

## III. Patient Share by Claim Type

| Year | Inpatient MH | Resident MH | Resident Chem Dep |
|---|---|---|---|
| 2006 | 13.5% | 30.6% | 17.3% |
| 2008 | 12.1% | 22.3% | 18.1% |
| Percent Change | -1.4% | -8.3% | 0.8% |

## IV. Average paid claim amount per visit

| | Inpatient Mental Health | | | Residential Mental Health | | | Residential Chemical Dependency | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | insurer | insured | total | insurer | insured | total | insurer | insured | total |
| 2006 | 2,204.19 | 343.28 | 2,547.46 | 174.07 | 76.72 | 250.80 | 1,090.60 | 228.36 | 1,318.96 |
| 2008 | 2,947.38 | 407.31 | 3,354.69 | 217.59 | 62.31 | 279.90 | 962.25 | 213.12 | 1,175.37 |
| Change | 743.19 | 64.03 | 807.23 | 43.52 | (14.41) | 29.10 | (128.35) | (15.24) | (143.59) |
| Percent Change | 33.7% | 18.7% | 31.7% | 25.0% | -18.8% | 11.6% | -11.8% | -6.7% | -10.9% |

**V. Number of visits by facility**

| Year | Inpatient MH | Resident MH | Resident Chem Dep |
|---|---|---|---|
| 2006 | 5,999 | 33,330 | 4,869 |
| 2008 | 5,629 | 23,360 | 8,257 |
| Change | (370) | (9,970) | 3,388 |
| Percent Change | -6.2% | -29.9% | 69.6% |

**VI. Frequency - visits per member month**

| Year | Inpatient MH | Resident MH | Resident Chem Dep |
|---|---|---|---|
| 2006 | 0.04% | 0.20% | 0.03% |
| 2008 | 0.03% | 0.14% | 0.05% |
| Percent Change | -0.01% | -0.06%$ | 0.02% |

**VII. Percent of visits by facility**

| Year | Inpatient MH | Resident MH | Resident Chem Dep |
|---|---|---|---|
| 2006 | 0.1% | 0.3% | 0.05% |
| 2008 | 0.1% | 0.2% | 0.08% |
| Percent Change | 0.0% | -0.1% | 0.03% |

# 2009 Review of Coverage of Mental or Nervous Conditions

# and Chemical Dependency

# in Accordance with OAR 836-053-1405 (8)

Department of Consumer and Business Services

Insurance Division

Senate Bill 1 enacted during the 2005 legislative session requires that health insurance coverage for the treatment of mental health or nervous conditions and chemical dependency be in parity with other medical coverage. The bill was enacted in part to end the disparity in insurance coverage for psychiatry and medicine and to unify treatment of the whole person - mind and body.

The legislation requires that group health insurance policies provide treatment benefits for chemical dependency and for mental or nervous conditions at the same level and subject to limitations no more restrictive than those imposed for treatment of other medical conditions. The legislation prohibits specific visit limits for mental health treatment not required for other medical conditions and eliminates differences in co-payments, coinsurance, deductibles, maximum out of pocket expenses and lifetime maximum benefits for chemical dependency and mental health or nervous condition treatments that were previously permitted.

## Background

Oregon has required mental health benefits for group insurance plans since 1975. In 1987 Oregon combined mental health and chemical dependency coverage laws and established separate dollar limits for adults and children. By 1998, all insurers offering group health benefit plans used durational limits that limited the number of mental health visits they covered. In 1999, Oregon increased the minimum dollar coverage requirements by 25%. After this increase, chemical dependency treatment and mental health care were required for a number of visits that equaled $13,125 for adults and $15,625 for children under 18 years old. Until passage of SB 1, insurers were permitted to carve out and not cover mental health prescription medications even when prescriptions were covered for other medical conditions.

Senate Bill 1, codified at ORS 743A.168, was passed by the 2005 Oregon Legislature and became effective January 1, 2007 or the first policy renewal date thereafter. In passing Senate Bill 1, Oregon joined 32 other states that enacted mental health parity laws and 14 additional states that expanded mental health coverage.

## Exclusions

ORS 743A.168 does not apply to all types of health insurance. Individual health plans, self-insured employer group health plans, disease specific insurance plans, long term care plans, disability plans, Medicare, and Medicaid are not required to comply.

ORS 743A.168 (4) (a) does not apply to all services. Educational and correctional services, long term residential mental health treatment lasting longer than 45 days, psychoanalysis or psychotherapy received as part of an educational or training program, court ordered sex offender, and court-ordered DUII screening and treatment are excluded. ORS 743A.168 (6) excludes reimbursement for support groups and ORS 743A.168 (7) permits insurers to limit coverage for in-home services.

## Application of the Law

**Reimbursement.** Senate Bill 1 specifies that a provider is eligible for reimbursement for the treatment of mental health, nervous conditions and chemical dependency if the provider is approved by the Department of Human Services, is accredited, and provides a covered benefit under the health insurance policy. Eligible providers include health care facilities, residential programs or facilities, day or partial hospitalization programs, outpatient services, inpatient services, and licensed providers practicing within the scope of their licenses.

**Policy Provisions.** The law does not specify the amount of reimbursement for treatment. Rather, coverage for chemical dependency and mental or nervous conditions is subject to the provisions of the policy that apply to other benefits including medical necessity, deductibles, copayment, coinsurance, reimbursement, and treatment limitations.

**Management tools.** Senate Bill 1 does not prohibit insurers from managing benefits for mental health, nervous conditions and chemical dependency through common methods such as prior authorization, which requires that the insurer authorize treatment before it is provided, and utilization review, which allows the insurer to review the medical necessity, use, and efficacy of the treatment as long as those requirements are imposed on the coverage for other medical conditions.

## Implementation

After passage of the new law, the Insurance Division worked with consumer groups and stakeholders and held several trainings and discussion groups to work on transition and implementation. In addition to the trainings and discussion groups, the Insurance Division hosted multi-stakeholder advisory meetings to seek input on the development of Oregon Administrative Rules to help implement the law. Insurers, providers, consumers, the Department of Human Services, and the National Alliance on Mental Illness (NAMI) representatives among others, participated in discussions used to draft and shape the Division's rules.

## Assessment of Implementation

Since implementation of the law on January 1, 2007, the Insurance Division has monitored compliance and resolved complaints. The Division has not seen significant consumer complaint activity related to Senate Bill 1 and mental health parity. The Division completed investigations and closed 51 complaint files. 49 of these files did not involve violations of Senate Bill 1, because they were either (a) filed by consumers with individual or self-insured plans, which are not subject to the requirements of the law (11 complaints); (b) made for services received prior to the effective date of the law (8 complaints); (c) related to administrative issues, poor customer service, delays in payment, incorrect identification numbers, or claims misinformation (12 complaints); or (d) related to denials due to lack of medical necessity, lack of coverage under the plan,

or because services were obtained from out-of-network providers (18 complaints). Under SB 1, insurers may deny or limit coverage for these reasons.

In the two consumer complaints where violations of Senate Bill 1 were found, contractual language specifically limiting coverage for developmental disorders and mental health and chemical dependency treatment was identified. The Division required the companies to remove the offending language and to comply with the mandates of Senate Bill 1.

The Division looked into insurers' uses of utilization review, treatment plan requirements, and contract language. We also reviewed the mental health, nervous conditions, and chemical dependency treatment policies and procedures of 14 insurers. The Division found contract language in violation of Senate Bill 1, and worked with insurers to bring them into compliance.

## Cost-Benefit Estimates: claims & cost

The Congressional Budget Office and private actuarial firms estimated the impact of parity on health insurance premiums and reported rate increases ranging from 3.2% to 11.4%. The expected average increase in Oregon health insurance premium rates was estimated at 1.5%. As of the third quarter of 2008, three carriers estimated the effects of the law on rates. According to the information filed by these carriers, Senate Bill 1 caused rate increases ranging from one-half of one percent to approximately two percent.

The Division will be conducting a data call of insurers during the first quarter of 2009 requesting claims and expenditure information about mental health, nervous conditions, and chemical dependency treatment. Once compiled and analyzed, the data should show how much mental health, nervous disorder, and/or chemical dependence claims and cost increased or decreased since the passage of Senate Bill 1 on a per member per month basis.

House Committee on Business and Consumer Affairs January 31, 1991 - Page

These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks

report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

HOUSE COMMITTEE ON BUSINESS AND CONSUMER AFFAIRS

January 31, 1991 Hearing Room F 1:15 p.m. Tapes 15 - 16

MEMBERS PRESENT: Rep. John Schoon, Chair Rep. Hedy L. Rijken, Vice-Chair Rep. Jerry Barnes Rep. Lisa Naito Rep. Carolyn Oakley Rep. Beverly Stein Rep. Greg Walden

STAFF PRESENT: Terry Connolly, Committee Administrator Annetta Mullins, Committee Assistant

MEASURES CONSIDERED: HB 2396 PH HB 2040 PH

These minutes contain materials which paraphrase and/or summarize statements made during this session. Only text enclosed in quotation marks report a speaker's exact words. For complete contents of the proceedings, please refer to the tapes.

TAPE 15, SIDE A

010 CHAIR SCHOON calls the meeting to order at 1:19 p.m. and opens the work session for purposes of introduction of measures.

INTRODUCTION OF MEASURES

015 MIKE McCALLUM, Director, Oregon Restaurant Association, submits a prepared statement and hand-engrossed version of HB 2304. He summarizes a prepared statement and requests the committee introduce the amended version of HB 2304 (EXHIBIT A).

055 CHAIR SCHOON: I note there are fee increases in the bill.

057 MR. McCALLUM: That is from the other bill. We think those fees will cover the cost of administering the program adequately through the Department of Agriculture. We are in consultation with them to determine if those fees are adequate; we are not married to those fees.

062 MOTION: Rep. Rijken moves that the committee introduce the proposed draft (EXHIBIT A, pages 3 - 8), as submitted by Mr. McCallum, at the request of the Oregon Restaurant Association.

071 VOTE: In a roll call vote, REPS. NAITO, OAKLEY, STEIN, WALDEN, RIJKEN AND CHAIR SCHOON vote AYE. REP. BARNES IS EXCUSED.

076 CHAIR SCHOON declares the motion PASSED.

075 DAN DOYLE, representing Eric Lindauer, consumer member on the State Board of Agriculture and a member of the Consumer Advisory Council,

Exhibit D
Page 1 of 6

explains the draft and reasons for requesting the introduction of LC 2609 (EXHIBIT B): >proposes a position of consumer officer for Department of Agriculture. >position existed from 1972 to June 1982; was cut out in the special session. >position has been filled on a half-time basis by various department personnel. >primary consideration for the position is to conduct educational activities for consumers and industry groups.

113 REP. NAITO: Does the Department of Justice do any of this kind of work?

115 MR. DOYLE: At this time it is performed only by the department by a position that is not even half time.

121 MOTION: REP. RIJKEN moves that the committee introduce LC 2609 at the request of Eric Lindauer (Consumer Advisory Council, Oregon Department of Agriculture).

124 VOTE: In a roll call vote, REPS. NAITO, OAKLEY, STEIN, WALDEN, RIJKEN and CHAIR SCHOON vote AYE. REP. BARNES IS EXCUSED.

126 CHAIR SCHOON declares the motion PASSED.

133 CHAIR SCHOON opens the public hearing on HB 2396.

HB 2396 - REQUIRES HEALTH INSURANCE PAYMENT FOR SERVICES TO VICTIMS OF CHILD SEXUAL ABUSE. Witnesses:Mary Hoyt, Chair, Task Force on Sex Offenses Against Children Al Thompson, Blue Cross/Blue Shield Jim Swenson, Administrator, Insurance Division, Dept. of Insurance and Finance

138 MARY HOYT, Chair, Task Force on Sex Offenses Against Children: Since our last meeting, we have gone through some of our records, but not all, and we will need to go back through our notes to determine the names of persons and insurance companies. We also received some information from the Victims Assistance Program about people who have insurance that does not cover the treatment and a list of reasons why Victims Assistance would pick up the coverage. They didn't have any instances where an insurance company had denied a claim because of sexual assault.

Our intent in the task force was not to get into all the other issues of insurance, but just to make sure the young victims have coverage. Mr. Thompson and I have been talking about how to accomplish that. We discussed inserting in the statutes after "mental or emotional illness" "to include victims of sex abuse." Mr. Thompson suggested that won't accomplish it because that is already there. We looked at how to get the consumers to understand that their insurance would cover treatment. The insurance coalition has suggested they include examples in their brochures. Another suggestion was to get the Oregon Insurance Consumer Advocate involved to look at situations as they come up. That may be enough to accomplish what the task force wanted.

175 CHAIR SCHOON: How about the self-insurers?

184 MS. HOYT: About one-half the people covered in Oregon are covered by self-insurers, not by the companies that are mandated to cover mental or emotional disturbances.

191 AL THOMPSON, Blue Cross/Blue Shield: I believe the Insurance Division is here and perhaps they could follow up.

200 REP. STEIN: Is it possible we can do this without legislation?

212 MS. HOYT: It may be and that is all we want to do.

220 CHAIR SCHOON: We heard testimony from representatives of the

insurance companies that insurance companies do treat people who have been sexually abused as a nervous or mental disorder. There didn't seem to be any dispute. Is that what you understood also?

227 MR. THOMPSON: Yes.

230 CHAIR SCHOON: "I would like for us to note for the legislative record that the industry, and therefore, we as a legislative body understand that sexual abuse is one of the items covered under mental and nervous disorders as covered in the statutes."

241 REP. STEIN: It seems she has said a pre-existing condition means treatment had already been started prior to getting insurance and then there is a waiting period before you are allowed to get treatment. If you hadn't been treated, it is still a pre-existing condition in the sense that the incident that is triggering the need for treatment happened prior to getting the insurance. Does that mean you get first-day coverage?

246 MR. THOMPSON: If there is a pre-existing clause in the contract, it would state "if you have been treated for this condition within three or six months prior to this coverage starting" then you may have to wait that period for coverage. The fact the sexual abuse occurred three or 10 years ago would not be considered a pre-existing condition as far as being eligible for treatment.

250 CHAIR SCHOON: Do you know of any complaints from persons not being provided coverage for sexual abuse when they were covered by insurance that had mandated coverage for mental and nervous disorders.

268 MR. SWENSON: We have had no specific complaint from a consumer who has been denied coverage as a victim of child abuse. There are a few issues I would like to discuss in general terms. >All health insurance policies covers treatment that is medically necessary. The Division is unaware of any policies that would specifically exempt such coverage unless it was a pre-existing condition. >Some policies provide limited benefits that relate to psychological problems. ORS 743.556 mandates that Oregon-based health insurance policies provide coverage for mental health services requiring they be subject to the same co-insurance and deductibles as other medical services, although they are subject to some internal limits. >The mandate does not apply to other forms of insurance such as self-insurance plans. Roughly 50 percent of the people are covered by self-insurance. >Insurance Pool Governing Board is not subject to state mandated benefits. That program might become mandated in 1994 unless certain enrollment targets are not achieved. >In addition, out-of-state groups, would not be subject to the mandated benefits. Generally, most do provide some coverage for psychological problems at 50 percent rather than the typical 80 percent. >As indicated before, we have not received complaints from consumers, but have from providers in efforts of containing health care costs. >If an individual believes he/she has been inappropriately denied coverage, our Complaint Resolutions and Investigations Section stands ready to intercede on their behalf.

344 CHAIR SCHOON: What is meant by an "Oregon based policy?"

MR. SWENSON: It is written in Oregon according to Oregon law. A policy issued through a California employer for employees in Oregon would be subject to California law.

367 CHAIR SCHOON: It appears we have a solution without legislation and it appears to be the most appropriate choice. Mary Hoyt and the task force will continue to search their records in an attempt to find specific examples that relate to specific companies that may not have honored this provision. Mr. Swenson will keep us informed about complaints received by the Insurance Division.

397 CHAIR SCHOON closes the public hearing on HB 2396 and opens the

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Page 3 of 6

public hearing on HB 204 0.

HB 2040 - ESTABLISHES SPECIAL PROGRAM FOR TELEPHONE ACCESS FOR PHYSICALLY DISABLED. Witnesses: Maury Astley, Oregon Independent Telephone Association Eugene Organ, Executive Director, Oregon Disabilities Commission Carl Garner, member, Oregon Disabilities Commission Pat Fawcett, Administrator, OTAP Jack R. Cassell, Telecommunications for Deaf and Hearing Impaired Jim Sexton, Administrator, Public Utility Commission

415 MAURY ASTLEY, Oregon Independent Telephone Association: Our concern is that federal legislation requires telephone companies to provide the deaf relay system and fund it if it is not done by the state in a way that meets the federal mandates. I don't have any question about meeting the deadline. My concern is in working with the advisory committee. The funds for adding operators to the system really haven't been earmarked. We are still trying to decide at the advisory committee level at what time we should bring enough operators on, whether we should bring them on now and spend the money before we have to meet the federal guideline or should we wait until next year when the 1988 act becomes effective.

My concern is not so much with adding this new program, but making sure we get the deaf relay system up to standards before we started using the money for other programs.

TAPE 16, SIDE A

041 REP. NAITO: Do you think it would be preferable to put some sort of priority in the legislation for the deaf relay system or do you feel comfortable that the board would be able to work that out?

044 MR. ASTLEY: You can do it either of two ways: leave it to the discretion of the board or make the effective date January 1992, or just put language of preference in there. Mr. Organ said they are satisfied with finishing the deaf program first.

065 REP. NAITO: If you bring the system up to the federal mandates and increased the consumers being served, would you foresee the surcharge going back up to 25 cents.

067 MR. ASTLEY: There are two funds now, although the telephone bill shows a 25 cent charge. One is a 15 cent program for the low income and the other is a 10 cent program for the deaf relay and device program. The low-income program didn't need the 15 cents and therefore reduced it to five cents. The relay part of the other program is the most expensive because of the operators. That program may need more than the 10 cents. Another bill will give the commission the authority to co-mingle those funds. Currently, customers are seeing 15 cents on their bill; we might go back to 25 cents so the money is available for the deaf relay system and the disabled program and the teletypes for the deaf. OITA will support that bill.

080 EUGENE ORGAN, Executive Director, Oregon Disabilities Commission: At the last hearing we were talking about some additional information. We were able to obtain some examples of adaptive technology that we were talking about. Mr. Garner has those with him courtesy of AT&T. We have a brochure on the telecommunications section of the Americans with Disabilities Act (EXHIBIT C).

Since so much of the act applies to the business community, our commission will do a brief summation of the Act.

131 CARL GARNER, member of the Oregon Disabilities Commission, submits copies of the AT&T Product Catalog (EXHIBIT D) and displays and explains a variety of available devices.

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160 MR. ORGAN: The devices that would be made available to the consumers would be made by the PUC in consultation with the TDAP committee. We in no way have any intention of detracting from the present program for the deaf and speech and hearing impaired. We would be open to making it clear that we want to see the hearing impaired and deaf program maintained.

198 PAT FAWCETT, Administrator, Oregon Telephone Assistance Program (OTAP), submits a letter, brochure and summary of funds paid out through the OTAP program and reviews the letter explaining the program (EXHIBIT E).

289 CHAIR SCHOON: Do you perceive a funding problem as a result of the new federal standards?

302 MR. CASSELL: The FCC requirements haven't been written yet; we will need find out what they are going to require. Call blocking and the number of calls are cost factors that will influence the cost. Based on the figures we have so far, we expect to be able to cover any unexpected charges for the 1991-92 biennium. We think the balance will be about $3.5 million. That should be enough to pay for the relay service and the FCC requirements.

323 MS. FAWCETT: The federal requirements for the standards do not impact the OTAP program. We will not see any change in our funding or increase in the number of employees.

330 REP. BARNES: Are the telephone companies permitted to withhold a part of the surcharge for administrative expenses?

334 MS. FAWCETT: The money is clearly identified for these two programs. The telephone companies bill and collect the 15 cent surcharge and submit it to the commission on a monthly basis. The handout shows the carrier reimbursement for the telephone assistance program. The direct customer benefits over the $1 million is paid from PUC to the phone company, but that represents the customer credits. There is a $3.80 processing fee approved by the PUC for each enrollment or disconnection from the program. Administrative expenses for the 1987-89 biennium was $107,000. No other costs are paid to the phone companies. The administrative costs are the PUC's costs.

345 Issues further discussed: >Availability of services. >Marketing programs. >Availability of program to elderly persons in nursing homes.

TAPE 15, SIDE B

001 CHAIR SCHOON: How would you feel about us moving some of the unused funds from the low-income program to the telephone assistance program for the disabled since there is a concern about funding. You would still have considerable latitude for the low-income and we would alleviate the concerns for staffing for the physically disabled.

015 JIM SEXTON, Executive Director, Oregon Public Utility Commission (PUC): Currently, the laws calls for not more than 15 cents to go to low income assistance and not more than 10 cents to go to OTAP. The Chair was suggesting that rather than give the commission the flexibility to adjust the limitations that it be done by statutes and perhaps the 15 cents be lowered to 10 and the 10 cents be increased to 15 cents. That would be an interim solution to the problems identified here today.

The committee might be more comfortable by hearing from the committee; Mr. Astley represents that committee.

040 MAURY ASTLEY: As a member of the advisory committee and as a representative of the Oregon Independent Telephone Association, we are supporting the other legislation which gives the commission flexibility. I would support the Chair's concept to move five cents. From the beginning of this program we knew that in other states the deaf relay

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program had eaten up the original money that was allocated for it.

060 MR. SEXTON: The legislation Mr. Astley referred to was sponsored by the Public Utility Commission. The commission had not discussed changing the limitations; they had only discussed the flexibility. Since either proposal would meet their objectives, I think I would not be undermining their position by saying they would be agreeable.

068 CHAIR SCHOON: We will not go into work session and will give the parties time to reconsider and rethink their positions.

079 MS. FAWCETT: In HB 2222 we had proposed to expand the OTAP program to include people who are in several other low income groups, rather than isolate it to those on food stamps. However, based on the experience of the program today, we felt the five cent limit would serve those people.

088 REP. BARNES: Is there a reporting procedure set up for the PUC to tell the Legislature how well the program is going?

091 MR. SEXTON: We always report back to Ways and Means with our budget request. Often times reports are requested when programs are set up. I think we had some obligation to return to either the Legislature or the Emergency Board with a report of our experience with this program prior to this time.

101 REP. BARNES: I like the suggestion of flexibility, but if we were to go further, I think we would want feed back on how the flexibility is going.

105 CHAIR SCHOON: We will reschedule the bill for another public hearing and work session next Tuesday.

113 CHAIR SCHOON closes the public hearing on HB 2040 and declares the meeting adjourned at 2:23 p.m.

Respectfully submitted, Reviewed by,

Annetta MullinsTerry Connolly AssistantAdministrator

EXHIBIT SUMMARY

A -Introductions, prepared statement and legislative proposal, Mike McCallum B -Introductions, LC 2609, Dan Doyle C -HB 2040, brochure, The Americans with Disabilities Act, Eugene Organ D -HB 2040, product catalog, Carl Garner E -HB 2040, prepared statement, brochures and fiscal information, Pat Fawcett

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# Analysis Of Group Health Insurance Mandates Required By The Oregon Insurance Code

**By**

**The Oregon Insurance Pool Governing Board**

**March 12, 2004**

# Contents

Background 1

Discussion of Specific Mandates 3

Appendix A 17
The Full Text of the Referenced Oregon Revised Statutes and Oregon Administrative Rules

# Analysis Of Group Health Insurance Mandates Required By The Oregon Insurance Code

## Background

Oregon statutes require most group health insurance to provide certain coverage and benefits. These statutes are often referred to as mandates. These statutes, and the administrative rules adopted to implement them, require coverage for certain populations, that certain illnesses and conditions be covered, that certain treatments be included, and that certain providers be reimbursed when they provide covered services.

In 1984 the National Association of Insurance Commissioners (NAIC) categorized mandated benefits in three ways:

1. Population mandates—regulations requiring coverage of certain populations;
2. Benefit mandates—regulations requiring coverage of specific illnesses, procedures, or types of treatment; and
3. Provider reimbursement mandates—regulations requiring that care administered by certain health care providers be reimbursed if the care is a covered expense.

This paper provides a brief look at each of the Oregon statutes in these three categories.

As of January 1, 2004, Oregon has 25 mandates for health insurers. For insurers there are 4 population mandates, 11 benefit mandates and 10 provider reimbursement mandates. Three of the provider reimbursement mandates are almost "administrative" mandates because they require certain claims to be processed in a particular manner.

However, only 20, of the 25 mandates that apply to insurers, also apply to health care service contractors, such as Regence BlueCross BlueShield of Oregon and Kaiser Permanente. For health care service contractors there are 4 population mandates, 11 benefit mandates and 5 provider reimbursement mandates. One of the provider reimbursement mandates is almost an "administrative" mandate because it requires certain claims to be processed in a particular manner. Whether or not a mandate applies to a health care service contractor is noted in the text.

Since 1985 many newly enacted mandates are subject to automatic repeal under ORS 743.700. This law provides for automatic repeal of mandate statutes that require coverage of populations, conditions, or providers, every six years when the mandate statute was effective after ORS 743.700 became law on July 13, 1985. Only seven of the current health insurer mandates are subject to automatic repeal in keeping with ORS 743.700. Only six of the mandates that apply to health care service contractors are subject to automatic repeal. There is further discussion of this statute on page 7 of the text.

In addition to the mandates referenced above, other statutes create requirements for health insurance contracts and health insurance carriers affecting the cost of health insurance. These

statutes are not considered mandates and thus not subject to automatic repeal. Examples of these statutes are:

ORS 743.527 requires an insurer to allow continuation of group health coverage during a strike or a lockout when the employer pays any part of the premium under the terms of a collective bargaining agreement. The statute further requires employees to continue to pay their individual contribution as well as the portion of the premium paid by the employer. Such coverage must be continued for 6 months.

ORS 743.610 requires continuation of coverage under a group health plan when employment terminates, membership in the insured group ends or there is dissolution of marriage that changes the dependent status of a person insured under the policy. The person continuing the coverage pays the premium. The affected person must be allowed to continue coverage for up to six months. This statute imposes these requirements on health plans sold to employers, with twenty or fewer employees, not subject to federal COBRA requirements.

ORS 743.734 requires the health insurance (Small Employer Health Insurance) issued to small employers (those employers with at least two and no more that 50 employees) covering employees and their dependents must be issued "...without regard to actual or expected health status of..." either the employees or dependents. The health insurance for these employees and dependents is guaranteed issue.

ORS 743.737 also imposes requirements on Small Employer Health Insurance. This statute requires small employer health benefit plans to be renewable, that specific notices are required for discontinuation of the plan, and that premium rates are subject to "rate bands".

ORS 743.758 and ORS 743.760 apply the federal requirement for portability and specify the benefits the insurer must offer to an insured requesting a portability policy.

ORS 743.804 requires a health insurance carrier offering a health benefit plan to establish a grievance and appeal process.

ORS 743.845 requires an insurer to allow a female enrollee to designate a women's health care provider as the enrollee's primary care provider, if the insurer requires the designation of primary care provider.

ORS 743.857 requires a health insurance carrier offering a health benefit plan to establish an external review process. This allows an insured to request an organization, not affiliated with the health insurer, review any denied claim to determine if the denial was in keeping with the terms of the contract.

There are approximately 30 of these non-mandate requirements in the Insurance Code. As noted, these requirements can affect the cost of health insurance.

## Discussion of Specific Mandates

In this section, each of the statutes that are considered a population mandate, a benefit mandate or a provider reimbursement mandate is reviewed. The mandates are listed in statute number order. Three statutes that appear in the Insurance Code, but have been repealed by the action of ORS 743.700 are also discussed. An appendix that includes the full text of each statute and administrative rule referenced in the analysis is attached.

1. **ORS 743.556 Group health insurance coverage for treatment of chemical dependency, including alcoholism, and for mental or nervous conditions; rules.**

This statute is a benefit mandate. The statute requires group health insurance policies to provide coverage for hospital or medical expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions. 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. The statute provides a minimum level of benefit for both mental health and chemical dependency. The minimum benefit is also different for adults and children age 17 or younger. In addition, the benefits are required for a number of treatment settings. The table below illustrates the minimum benefits required by Sections 6, 10, 11, 12 and 13 of the statute.

| | **Total Required Benefits**<br>Section 6 | |
|---|---|---|
| **Type of Care** | **Adults** | **Children** (Age 17 or younger) |
| Chemical Dependency and Mental Health | $13,125 | $15,625 |
| Chemical Dependency Only | $8,125 | $13,125 |

| | | **Chemical Dependency Benefits** | | **Mental Illness Benefits** | |
|---|---|---|---|---|---|
| **Statute Section** | **Type of Care** | **Adults** | **Children** (Age 17 or younger) | **Adults** | **Children** (Age 17 or younger) |
| Section 10 | Inpatient Care | $5,625 | $5,000 | $5,000 | $7,500 |
| Section 11 | Residential, Partial Hospitalization, and Day Care | $4,125 | $3,750 | $4,125 | $3,125 |
| Section 12 | Total Benefit Inpatient, Residential, Partial Hospitalization, Day Care | Does Not Apply | $10,625 | $10,625 | $13,125 |
| Section 13 | Outpatient Care | $1,875 | $2,500 | $2,500 | $2,500 |

In Section 6, the statute requires benefits for the treatment of chemical dependency, together with the treatment of any mental or nervous condition, not be less than $13,125 for adults and $15,625 for children 17 and younger. Section 6 also requires that benefits for treatment of chemical dependency alone not be less than $8,125 for adults and $13,125 for children 17 and younger.

In Section 10(a), the statute requires that benefits for inpatient treatment of chemical dependency be at least $5,625 for adults and $5,000 for children 17 and younger. In Section 10(b), the statute requires benefits for inpatient treatment of mental and nervous conditions are at least $5,000 for adults and $7,500 for children 17 and younger.

In Section 11(a), the statute requires that benefits for residential, partial hospitalization, and day care treatment of chemical dependency be at least $4,375 for adults and $3,750 for children 17 and younger. In Section 11(b), the statute requires benefits for residential, partial hospitalization, and day care treatment of mental and nervous conditions is at least $1,250 for adults and $3,125 for children 17 and younger.

In Section 12(a), the statute requires the combined benefits for inpatient, residential, partial hospitalization, and day care treatment of chemical dependency is at least $10,625 for children 17 and younger. The total combined benefit required by Sections 10(a) and 11(a) for children 17 and younger is $8,750. Thus, Section 12(a) requires an additional benefit, not assigned to any treatment category, of $1,875 for children 17 and younger. In Section 12(a) there is no additional requirement for adult treatment of chemical dependency. In Section 12(b), the statute requires the combined benefits for inpatient, residential, partial hospitalization, and day care treatment of mental and nervous conditions is at least $10,625 for adults and $13,125 for children 17 and younger. The total combined benefit required by Sections 10(b) and 11(b) for adults is $6,250. For children 17 and younger the total combined benefit required by Sections 10(b) and 11(b) is $8,750. Thus Section 12(b) requires an additional benefit of $4,375 for adults and $2,500 for children 17 and younger that is not assigned to any treatment category.

In Section 13(a), the statute requires benefits for outpatient treatment of chemical dependency is at least $1,875 for adults and $2,500 for children 17 and younger. In Section 13(b), the statute requires benefits for outpatient treatment of mental and nervous conditions are at least $2,500 for both adults and children 17 and younger.

In ORS 743.556 (8), the Legislative Assembly stated the rationale for the higher benefits for children 17 or under. That section states:

> The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.

The benefits required by this statute are a 24-month benefit. If the benefit maximum is reached within 24 months, no further benefits will be paid. The benefits renew on the first

day of the 25th month following the use of services or the first day following two consecutive contract years.

The statute also allows the carrier to use durational benefits, benefits that are expressed in days of service, which are actuarially equivalent to the required dollar benefits. The table below illustrates the actuarially equivalent days provided by the Oregon Medical Insurance Pool (OMIP).

**Chemical Dependency**

| Type of Care | Adults | Children (Younger than 17) |
|---|---|---|
| Inpatient Care | 13 Days | 27 Days |
| Residential/Partial Hospitalization/Day Care | 19 Days | 26 Days |
| Outpatient Care | 25 Visits | 36 Visits |

**Mental Illness**

| Type of Care | Adults | Children (Younger than 17) |
|---|---|---|
| Inpatient Care | 15 Days | 16 Days |
| Residential/Partial Hospitalization/Day Care | 17 Days | 20 Days |
| Outpatient Care | 34 Visits | 34 Visits |

Originally ORS 743.556 was enacted as two statutes. ORS 743.557, effective in 1975, required coverage of chemical dependency, including alcoholism and ORS 743.558, effective in 1973, required coverage of mental and nervous conditions. Both statutes were reenacted into ORS 743.556 in 1987. Since the 1987 action was a reenactment, ORS 743.556 is not subject to repeal in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**2. ORS 743.691 Reimbursement for mastectomy-related services.**

This statute is a benefit mandate. House Bill 3624, (Chapter 748 Oregon Laws 2003) enacted by the 2003 Legislative Assembly, requires that all health benefit plans provide certain mastectomy-related services. The statute requires benefits for all stages of breast reconstruction, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of complications of the mastectomy, and inpatient care, on the same terms and conditions as other benefits of the plan. The statute also requires notice of these benefits at enrollment and annually thereafter, a single prior authorization, and expedited external review, if the enrollee requests external review of an adverse decision. The provisions of ORS 743.691 are very similar to the requirements of the federal Women's Health and Cancer Rights Act of 1998.

Chapter 748 Oregon Laws 2003 also removed three statutory requirements that health plans include provisions of the federal Women's Health and Cancer rights Act of 1998, P.L. 105-277. The three requirements amended are: ORS 743.737(15), affecting Small Employer Health Insurance; 743.754(9), affecting other group health insurance; and 743.766(9), affecting individual health plans. Each of the referenced sections was amended out of the statute.

The statute was effective January 1, 2004. This statute is exempted from repeal under ORS 743.700. No specific repeal provision was included in the statute. This statute is included in ORS 750.055 and applies to a health care service contractor.

**3. ORS 743.693 Reimbursement for pregnancy and childbirth expenses.**

This statute is a benefit mandate. The statute requires that all health benefit plans provide reimbursement for expenses associated with pregnancy care and childbirth. The benefits required by this statute are provided to all enrollees, enrolled spouses and enrolled dependents.

Oregon Labor Law and Administrative Rules also address this issue. The following labor law and rules require an employer to provide benefits for pregnancy, on the same basis as any other illness, if health benefits are provided for other conditions and these statutes and rules also prohibit an employer from discriminating between an employee and a dependent spouse in providing this benefit:

ORS 659A.029 "Because of sex" defined for ORS 659A.030.
ORS 659A.030 Discrimination because of race, religion, color, sex, national origin, marital status or age prohibited.
OAR 839-005-0021 Gender Discrimination
OAR 839-005-0026 Protections and Rights Relating to Pregnancy

If the Insurance Pool Governing Board offered a health plan that completely excluded pregnancy benefits, any employer purchasing such a plan would potentially violate Oregon Labor Law. This insurance statute, in effect, extends the requirement for pregnancy benefits to **"...enrolled dependents."** The Insurance Pool Governing Board could offer a health plan to employers that would not violate labor law while excluding pregnancy benefits for "enrolled dependents". This statute was effective in October 1999 and is subject to repeal in October 2005, in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**4. ORS 743.694 Reimbursement for diabetes self-management programs.**

This statute is a benefit mandate. The statute requires coverage of diabetes self-management programs "Subject to other terms, conditions and benefits in the plan..." This statute was reenacted in 2001. The previous statute, ORS 743.704, was repealed. The new statute removes the requirement of a first dollar benefit. The new statute was effective on January 1, 2002. The statute also places limits on how much training is required. A high deductible plan, that does not provide this benefit on a first

dollar basis or with a modest copay, would often not pay a claim for these services. Benefits for this service would not be paid because the insured had not met the deductible. Since this statute was effective on January 1, 2002 this statute is subject to repeal, in keeping with ORS 743.700, on January 1, 2008. This statute is included in ORS 750.055 and applies to a health care service contractor.

**ORS 743.695 Definition for ORS 743.697.**

This statute provides definitions; it does not mandate any populations, benefits or provider reimbursements be covered.

**5. ORS 743.697 Coverage of particular drugs.**

This statute is a benefit mandate. However, this statute does **not** require the general coverage of prescription drugs. This statute only establishes requirements for the benefits, if prescription drugs are covered under the health insurance policy.

This statute does regulate the determination of whether benefits for a particular use of a drug may be denied by the carrier. The statute establishes criteria that may require coverage in certain instances when the United States Food and Drug Administration has not approved a use of the drug. Uses that do not have FDA approval are often called "off label uses". The statute requires action by the Oregon Health Resources Commission, to determine the "off label use" is effective, before the coverage of the use is required. Health Resources Commission staff advised IPGB staff the Commission has never taken the action described in this statute. There has been no determination that an "off label use" of any drug is effective. This statute was effective in 1997, but contains an exemption from ORS 743.700. This statute is not subject to automatic repeal. This statute is included in ORS 750.055 and applies to a health care service contractor.

**6. ORS 743.699 Coverage of emergency services.**

This statute is a benefit mandate. The statute requires the coverage of emergency services without prior authorization. In some cases the statute also requires coverage of services provided by a nonparticipating provider. Carriers are required to provide a plain language notice explaining the coverage.

This statute was originally effective in 1997. This statute was subject to repeal, in keeping with ORS 743.700, in 2003. The 2003 Legislative Assembly reenacted this statute in HB 2642. The reenactment of the statute included both an exemption from ORS 743.700 and a specific repeal section, effective October 4, 2009. HB 2642 became Chapter 136 Oregon Laws 2003. This statute is included in ORS 750.055 and applies to a health care service contractor.

**ORS 743.700 Automatic repeal of certain statutes on individual and group health insurance.**

This statute does not mandate any populations, benefits or providers be covered. This statute does, however, affect other statutes that require those types of coverage. This statute generally provides for automatic repeal of statutes that require these coverages every six years, if the statute was effective after July 13, 1985, the effective date of this law. If the Legislative Assembly does not act, the statute is repealed. As noted in each statute discussed in this memo, some statutes are subject to this statute, some statutes have been specifically exempted from this statute, or some statutes were originally effective before July 13, 1985.

The 2003 Legislative Assembly passed three bills reenacting existing mandate statutes. As previously noted ORS 743.699 was reenacted in HB 2642; ORS 743.725 was reenacted in SB 646; and ORS 743.726 was reenacted in SB 74. Legislative counsel used a new method of subjecting these three statutes to automatic repeal. Each of these three statutes was exempted from ORS 743.700, but each statute now has a date specific repeal provision contained within the statute.

Three statutes discussed in this paper, ORS 743.717, ORS 743.722, and ORS 743.729 have been repealed by the operation of ORS 743.700. Even though these statutes have been repealed by the operation of this statute, they have not been removed from the Insurance Code. Legislative Counsel has advised they do not believe they have the authority to remove a statute from the Insurance Code, without direct authorization from the Legislative Assembly. Legislative Counsel does not believe the operation of ORS 743.700 provides direct authorization to remove a statute.

Since the text of these three repealed statutes still appears in the Insurance Code, they are discussed in this paper. These three statutes are not included in the mandate count of 25 mandates for health insurers and 20 mandates for health care service contractors.

7. **ORS 743.701 Reimbursement for services performed by state hospital or state approved program.**

This statute is a provider reimbursement mandate. This statute prohibits exclusion of benefits because the covered services are provide by any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program. This statute does not require any services to be included in the policy. This statute was effective in 1971 and is not subject to repeal by ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

8. **ORS 743.703 Reimbursement for services of optometrist.**

**ORS 750.065 Reimbursement for services performed by optometrists.**

These two statutes are a single provider reimbursement mandate. (ORS 743.703 applies to insurers, while ORS 750.065 applies to health care service contractors. In all other

cases, except where specifically noted, ORS 750.055 applies the statutes in this memo to health care service contractors.) These statutes require the insurer or health care service contractor to provide reimbursement for any service that is within the lawful scope of practice of a duly licensed optometrist, if the policy provided benefits when a physician performed the service. Neither of these statutes requires any services to be included in the policy. These two statutes were effective before July 13, 1985, ORS 743.703 was effective in 1967 and ORS 750.065 was effective in 1971. Neither statute is subject to repeal, in keeping with ORS 743.700.

**9. ORS 743.706 Reimbursement for maxillofacial prosthetic services.**

This statute is a benefit mandate. The statute requires coverage of maxillofacial prosthetic services under certain conditions:

Controlling or eliminating infection;
Controlling or eliminating pain; or
Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

The benefits required by this statute "... 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." This statute was effective in 1981 and is not subject to repeal in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**10. ORS 743.707 Health insurance coverage for newly born and adopted children.**

This statute is a population mandate. The statute requires coverage of newly born or adopted children if family coverage is provided. If a premium is required for coverage of the child to be effective, the statute provides a 31 day period for notice of the birth or adoption to be provided to the insurer and any required premium paid. This statute is specifically exempted from the repeal statute, ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

Oregon labor law, ORS 659.830, *Prohibition on limiting coverage under employee benefit plan based on eligibility to receive benefits under Title XIX of Social Security Act; prohibitions on limiting coverage under group health plans; requirements for group health plans*, also requires that an employer not limit enrollment of a child placed for adoption solely due to a preexisting condition.

**11. ORS 743.709 Reimbursement for services provided by psychologist.**

This statute is a provider reimbursement mandate. The statute requires the insurer to provide reimbursement for any service that is within the lawful scope of practice of a duly licensed psychologist, if policy provided benefits when a physician performed the service. This statute does not require the services to be included in the policy. This statute was effective in 1975 and is not subject to repeal in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

## 12. ORS 743.710 Denial or cancellation of health insurance because of use by mother of diethylstilbestrol.

This statute is a population mandate. The statute prohibits an insurer from denying or canceling health insurance solely because the insured person's mother used diethylstilbestrol (DES). Like ORS 743.707, *Health insurance coverage for newly born and adopted children*, this statute does not require a particular reimbursement, but rather limits an insurers ability to deny or limit access to health insurance. The guaranteed issue requirements of Small Employer Health Insurance Reform, ORS 743.737(6), may have effectively rendered this statute moot for employers with 2 to 50 employees. This statute was effective in 1979 and is not subject to repeal, in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

The following information about DES is from the National Cancer Institute:

> DES is a synthetic form of estrogen, a female hormone. It was prescribed between 1940 and 1971 to help women with certain complications of pregnancy. Use of DES declined in the 1960s after studies showed that it is not effective in preventing pregnancy complications. When given during the first 5 months of a pregnancy, DES can interfere with the development of the reproductive system in a fetus. For this reason, although DES and other estrogens may be prescribed for some medical problems, they are no longer used during pregnancy.
>
> In 1971, DES was linked to an uncommon cancer (called clear cell adenocarcinoma) in a small number of daughters of women who had used DES during pregnancy. This cancer of the vagina or cervix usually occurs after age 14, with most cases found at age 19 or 20 in DES-exposed daughters. Some cases have been reported in women in their thirties and forties. The risk to women older than age 40 is still unknown, because the women first exposed to DES in utero are just reaching their fifties, and information about their risk has not been gathered. The overall risk of an exposed daughter to develop this type of cancer is estimated to be approximately 1/1000 (0.1 percent). Although clear cell adenocarcinoma is extremely rare, it is important that DES-exposed daughters be aware of the risk and continue to have regular physical examinations.
>
> There is some evidence that DES-exposed sons may have testicular abnormalities, such as undescended testicles or abnormally small testicles. The risk for testicular or prostate cancer is unclear; studies of the association between DES exposure in utero and testicular cancer have produced mixed results. In addition, investigations of abnormalities of the urogenital system among DES-exposed sons have not produced clear answers.

## 13. ORS 743.712 Reimbursement for services of nurse practitioner.

This statute is a provider reimbursement mandate. The statute requires the insurer to provide reimbursement for any service that is within the lawful scope of practice of a

duly licensed and certified nurse practitioner, if policy provided benefits when a physician performed the service. This statute does not require any services to be included in the policy. This statute does not apply to federally qualified HMOs. This statute was effective in 1979 and is not subject to repeal in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**14. ORS 743.713 Reimbursement for services of denturist.**

This statute is a provider reimbursement mandate. This statute applies to insurance covering dental services. The statute requires the insurer to provide reimbursement for any service that is within the lawful scope of practice of a licensed denturist if policy provided benefits when a dentist performed the service. This statute does not require any services to be included in the policy. This statute was effective in 1979 and is not subject to repeal in keeping with ORS 743.700. This statute is not included in ORS 750.055 and does not apply to a health care service contractor.

**15. ORS 743.714 Reimbursement for services of clinical social worker.**

This statute is a provider reimbursement mandate. The statute requires the insurer to provide reimbursement to a licensed clinical social worker when a service is within the lawful scope of practice of the licensed clinical social worker and a physician or psychologist referred the insured to the licensed clinical social worker. This reimbursement is required only if the policy provided benefits when a physician or psychologist performed the service. This statute does not require any services to be included in the policy. This statute was originally effective in 1981 and is not subject to repeal in keeping with ORS 743.700. This statute is not included in ORS 750.055 and does not apply to a health care service contractor.

**ORS 743.717 Tourette Syndrome; reimbursement for treatment.**

This statute was a benefit mandate. The statute required that reimbursement for treatment of Tourette Syndrome was made on the basis of the diagnosis and treatment modality employed.

This statute was never included in ORS 750.055. The terms of the statute itself applied the statute to a health care service contractor. The 1985 Legislative Assembly enacted this statute in HB 2034. The bill became Chapter 312 Oregon Laws 1985. The bill was approved by the Governor on June 26, 1985 and filed in the office of the Secretary of State on June 27, 1985. This bill was effective September 20, 1985, 90 days after the end of the Legislative Session. Section 3 of Chapter 312 says: "This Act applies to any contract entered into, amended, or renewed on or after January 1, 1986.". In a note the Insurance Code says "See 743.700". ORS 743.700 says statutes "...effective before July 13, 1985..." are not subject to its' repeal provisions. Since this statute was effective September 20, 1985, it was subject to ORS 743.700. This statute was repealed September 20, 1991.

Even though this statute has been repealed by the operation of ORS 743.700, it has not been removed from the Insurance Code. Legislative Counsel has advised they do not believe they have the authority to remove a statute from the Insurance Code without direct authorization from the Legislative Assembly.

**16. ORS 743.718 Method of payments for ambulance care and transportation.**

This statute is a provider reimbursement mandate. This statute is one of the three provider reimbursement mandates that are more an administrative mandate. This statute does not require that ambulance care and transportation be covered. If ambulance care and transportation are covered, the statute requires the claims be paid in a certain way. Insurers that provide coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless the policy provides for direct payment to the provider.

This statute is not subject to ORS 743.700. This statute is not included in ORS 750.055 and does not apply to a health care service contractor.

**17. ORS 743.719 Reimbursement for certain surgical services performed by dentists.**

This statute is a provider reimbursement mandate. The statute requires the insurer to provide reimbursement for any service that is within the lawful scope of practice of a licensed dentist, if policy provided benefits when a physician performed the service. This statute does not require any services to be included in the policy. This statute was effective in 1971 and is not subject to repeal in keeping with ORS 743.700. This statute is not included in ORS 750.055 and does not apply to a health care service contractor.

**18. ORS 743.721 Nondiscriminatory health insurance coverage for women.**

This statute is a population mandate. This statute requires the carrier to provide the same reimbursements for costs of maternity to unmarried women that it provides to married women and the same coverage for the child of an unmarried woman that the child of an insured married person receives. BOLI has advised IPGB that if an employer purchased a group health insurance policy that did not comply with this statute and "...made distinctions on this basis..." the employer "....would be in danger of violating Oregon's prohibition against discrimination based on marital status." As in the case of ORS 743.693, *Reimbursement for pregnancy and childbirth expenses*, should the Insurance Pool Governing Board offer a health plan that did not comply with ORS 743.721, any employer purchasing such a plan would potentially violate Oregon Labor Law.

This statute was effective in 1973 and is not subject to repeal in keeping with ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**ORS 743.722 Reimbursement for acupuncturist**

This statute was a provider reimbursement mandate. The statute required the insurer to provide reimbursement for any service that was within the lawful scope of practice of a licensed acupuncturist if policy provided benefits when a physician performed the service. This statute did not require any services to be included in the policy.

The 1995 Legislative Assembly amended this statute in SB 851. The bill became Chapter 79 Oregon Laws 1995. The bill was approved by the Governor on April 27, 1995 and filed in the office of the Secretary of State on April 28, 1995. This bill was effective July 1, 1995. In a note the Insurance Code says "See 743.700". ORS 743.700 says statutes "...effective before July 13, 1985..." are not subject to its' repeal provisions. Since this statute was effective July 1, 1995, it was subject to ORS 743.700. This statute was repealed July 1, 2001.

Even though this statute has been repealed by the operation of ORS 743.700, it has not been removed from the Insurance Code. Legislative Counsel has advised they do not believe they have the authority to remove a statute from the Insurance Code without direct authorization from the Legislative Assembly. Even though repealed, this statute is included in ORS 750.055.

**19. ORS 743.725 Claim submitted by physician assistant.**

This statute is a provider reimbursement mandate. This statute is one of the three provider reimbursement mandates that are more an administrative mandate. This statute requires insurers to pay claims submitted directly by certain physician assistants. These physician assistants are typically rural. ORS 677.515 (4) is referenced in this statute and says, in relevant part:

> (4) A physician assistant may provide medical services to patients in a setting where a supervising physician does not regularly practice if the following conditions exist:
>
> (a) Direct communication either in person or by telephone, radio, radiotelephone, television or similar means is maintained; and
>
> (b) The medical services provided by the physician assistant are reviewed by a supervising physician on a regularly scheduled basis as determined by the board.

This statute was effective in 1997. This statute was subject to repeal, in keeping with ORS 743.700, in 2003. The 2003 Legislative Assembly reenacted this statute in SB 646. The reenactment of the statute included an exemption from ORS 743.700 and a specific repeal section, effective October 4, 2009. SB 646 became Chapter 446 Oregon Laws 2003. This statute is not included in ORS 750.055 and does not apply to a health care service contractor.

**20. ORS 743.726 Reimbursement for inborn errors of metabolism.**

This statute is a benefit mandate. The statute requires coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist.

This statute was originally effective in 1997. This statute was subject to repeal, in keeping with ORS 743.700, in 2003. The 2003 Legislative Assembly reenacted this statute in SB 74. The reenactment of the statute included an exemption from ORS 743.700 and a specific repeal section, effective October 4, 2009. SB 74 became Chapter 263 Oregon Laws 2003. This statute is included in ORS 750.055 and applies to a health care service contractor.

**21. ORS 743.727 Reimbursement for mammo-grams; schedule of covered mammo-grams.**

This statute is a benefit mandate. The statute requires benefits for mammograms and establishes that the services must be provided after age 40 or when a woman is deemed to be at high risk for breast cancer. This statute was originally effective in 1993 and was amended effective July 1999. This statute is subject to repeal, in keeping with ORS 743.700, in July 2005. This statute is included in ORS 750.055 and applies to a health care service contractor.

**22. ORS 743.728 Reimbursement for pelvic examinations and Pap smear examinations; schedule of covered examinations.**

This statute is a benefit mandate. The statute requires benefits for pelvic examinations and pap smear examinations and requires the services be provided annually for women 18 to 64 years of age or when referred by her health care provider. This statute was originally effective in 1993 and was amended effective July 1999. This statute is subject to repeal, in keeping with ORS 743.700, in July 2005. This statute is included in ORS 750.055 and applies to a health care service contractor.

**ORS 743.729 Reimbursement for nonprescription enteral formula for home use; conditions.**

This statute was a benefit mandate. The statute required benefits for nonprescription enteral formula, when ordered by a physician, if the formula was medically necessary for the treatment of severe intestinal malabsorption and the formula comprised the sole source, or an essential source, of nutrition. Food is usually excluded in health insurance policies. Deductibles and coinsurance for elemental enteral formulas were to be no greater than those for any other treatment or condition under the policy. This statute was originally effective in 1993. Since this statute was effective in 1993, it was subject to ORS 743.700. The Legislative Assembly took no action to extend this statute and it was repealed in 1999.

Even though this statute has been repealed by the operation of ORS 743.700, it has not been removed from the Insurance Code. Legislative Counsel has advised they do not believe they have the authority to remove a statute from the Insurance Code without direct authorization from the Legislative Assembly. Even though repealed, this statute is included in ORS 750.055.

**23. ORS 743.823 Enforcement of Newborns' and Mothers' Health Protection Act of 1996.**

This statute is a benefit mandate. The statute requires the Department of Consumer and Business Services to enforce insurer compliance with the federal Newborns' and Mothers' Health Protection Act of 1996. If this statute had not been enacted, the federal government would be responsible for the enforcement of this statute not the State of Oregon. The federal statute provides for 48 hours of care for a vaginal delivery and 96 hours of care for a caesarian delivery.

This statute was effective in 1997, but is not subject to repeal under ORS 743.700. This statute is included in ORS 750.055 and applies to a health care service contractor.

**24. ORS 743.842 Emergency eye care services without referral from primary care provider.**

This statute is a provider reimbursement mandate. This statute is one of the three provider reimbursement mandates that are more an administrative mandate. This statute requires any insurer that offers a health benefit plan, that provides coverage of eye care services, to allow any enrollee to receive covered eye care services on an emergency basis without first receiving a referral or prior authorization from a primary care provider. This statute does not require coverage of eye care services. However, an insurer may require the enrollee to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures.

This statute was effective in 1999, but contains an exemption from ORS 743.700. This statute is not subject to automatic repeal. This statute is included in ORS 750.055 and applies to a health care service contractor.

**25. ORS 743.847 Medicaid not considered in coverage eligibility determination; state acquires right of individual to payment; prohibited ground for denial of enrollment of child; insurer duties.**

This statute is a population mandate. This statute requires that a health insurance carrier not deny enrollment of a child because the child was born out of wedlock; the child is not claimed as a dependent on the parent's federal tax return; or the child does not reside with the child's parent or in the insurer's service area.

The statute also prohibits a health insurance carrier from considering the availability or eligibility for medical assistance, in this or any other state, under Medicaid, when

considering eligibility for coverage or making payments under its group or individual health insurance for eligible enrollees, subscribers, policyholders or certificate holders.

This statute was effective in 1995, but contains an exemption from ORS 743.700. This statute is not subject to automatic repeal. This statute is included in ORS 750.055 and applies to a health care service contractor.

Oregon labor law also has requirements on this subject in ORS 659.830, *Prohibition on limiting coverage under employee benefit plan based on eligibility to receive benefits under Title XIX of Social Security Act; prohibitions on limiting coverage under group health plans; requirements for group health plans* and ORS 659.835, *Health insurance coverage for children of employees.* ORS 659.830 was formerly 659.322 and ORS 659.835 was formerly 659.324. These labor laws, enacted in 1991 and 1995, have many of the same requirements as ORS 743.847.

ORS 659.830 requires a group health plan not consider the availability or eligibility for medical assistance, in this or any other state, under 42 U.S.C. 1396a (section 1902 of the Social Security Act), Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificate holders.

ORS 659.835 requires a the employer to allow a parent to provide health coverage under the plan when a court or administrative order requires the parent to provide coverage:

> Permit the parent to enroll under family coverage a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.
>
> If the parent is enrolled but fails to make application to obtain coverage of the child, the employer shall enroll the child under family coverage when an application is made by the child's other parent, by the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program.

The employer shall not drop coverage of a child unless the employer is provided satisfactory written evidence that:

> The court order is no longer in effect, or
>
> The child is, or will be, enrolled in comparable coverage which will take effect no later than the effective date of the child being dropped from coverage, or
>
> The employer has eliminated family health coverage for all of its employees.

Again, as in the case of ORS 743.693, *Reimbursement for pregnancy and childbirth expenses*, and ORS 743.721, *Nondiscriminatory health insurance coverage for women*, should the Insurance Pool Governing Board offer a health plan that did not comply with ORS 743.847, any employer purchasing such a plan would potentially violate Oregon Labor Law.

# Appendix A
# The Full Text of the Referenced
# Oregon Revised Statutes and Oregon Administrative Rules

**ORS 743.556 Group health insurance coverage for treatment of chemical dependency, including alcoholism, and for mental or nervous conditions; rules.** 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. The following conditions apply to the requirement for such coverage:

(1) 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 care facilities or residential programs or facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall be considered eligible for reimbursement if it is provided by:

(a) Programs or providers described in ORS 430.010 or approved by the Department of Human Services under subsection (3) of this section.

(b) Programs accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities.

(c) Inpatient programs provided by health care facilities as defined in ORS 442.015. Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement.

(d) Residential programs or facilities described in subsection (3) of this section if the patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week.

(e) Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430.010 (4)(a) and which meet the standards established under subsection (3) of this section.

**ORS 743.556 Continued**

(3) Subject to ORS 430.065, the Department of Human Services shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the department or any county mental health program. The department shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that are not related to the department or any county mental health program.

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Department of Human Services shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the department and any county mental health program.

(5) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Child or adolescent" means a person who is 17 years of age or younger.

(c) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than $13,125 for adults and $15,625 for children or adolescents. For persons requesting payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than $8,125 for adults and $13,125 for children and adolescents.

(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition.

**ORS 743.556 Continued**

(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.

(9) Payments shall not be made under this section for educational programs to which drivers are referred by the judicial system, nor for volunteer mutual support groups.

(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder:

(a) For chemical dependency to an amount less than $5,625 for adults and $5,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $5,000 for adults and $7,500 for children or adolescents.

(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs:

(a) For chemical dependency to an amount less than $4,375 for adults and $3,750 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $1,250 for adults and $3,125 for children or adolescents.

(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment:

(a) For chemical dependency to an amount less than $10,625 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $10,625 for adults and $13,125 for children or adolescents.

(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for outpatient services, the policy shall not limit payments:

(a) For chemical dependency to an amount less than $1,875 for adults and $2,500 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $2,500.

**ORS 743.556 Continued**

(14) If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health care facility, residential, day or partial hospitalization or outpatient services. The policy may limit coverage for in-home service to persons who have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(15) Under ORS 430.021 and 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(16) A group health insurance policy may provide, with respect to treatment for chemical dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to licensed clinical social workers, review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either insurer staff or personnel under contract to the insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment:

(A) This review shall be made according to criteria made available to providers in advance upon request.

(B) To facilitate implementation of utilization review programs by insurers, the Director of Human Services shall draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The director shall revise these criteria at least every two years. In developing and revising these criteria, the director shall organize a technical advisory panel including representatives of the Department of Consumer and Business Services, the Department of Human Services, the

insurance industry, the business community and providers of each level of care. The director shall place substantial weight on the advice of this panel.

(C) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon; a psychologist licensed by the State Board of Psychologist Examiners; a nurse practitioner registered by the Oregon State Board of Nursing; or a clinical social worker licensed by the State Board of Clinical Social Workers, with physician consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services.

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, insurers shall permit treatment providers, policy holders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Insurers shall provide a timely response to such inquiries. Approval of a particular admission does not represent a guarantee of future payment.

(E) An appeals process shall be provided.

(F) An insurer may choose to review all providers on a sampling or audit basis only; or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer.

(17) For purposes of subsection (16)(b) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(18) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility; or

(d) A day or partial hospitalization program.

**ORS 743.556 Continued**

(19) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(20) For purposes of subsection (16)(b) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis.

(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of $300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level.

(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

(23) Health maintenance organizations, as defined in ORS 750.005, shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees:

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other insurance policies which are subject to the provisions of this chapter for that type and level of service.

(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section.

**ORS 743.556 Continued**

(c) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization.

(d) The Department of Human Services shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection.

(24) Nothing in this section shall prevent an insurer or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section, from contracting with providers of health care services to furnish services to policy holders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available.

(b) An insurer or health care service contractor, other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section.

(c) An insurer or health care service contractor is not required to contract with all eligible providers, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section.

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(e) The department shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.

**ORS 743.556 Continued**

(25) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to assure continuing access to levels of care most appropriate for the insured's condition and progress.

(26) The director, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions. [1987 c.411 §2; 1989 c.721 §55; 1991 c.67 §198; 1991 c.470 §19; 1991 c.654 §2; 1999 c.1086 §1; 2001 c.900 §217; 2003 c.33 §5]

Note: Section 7, chapter 411, Oregon Laws 1987, provides:

Sec. 7. Application of ORS 743.700 to ORS 743.556 and 750.055. ORS 743.145 [renumbered 743.700] does not apply to section 2 of this Act [743.556] because section 2 of this Act constitutes a reenactment of ORS 743.557 and 743.558 or to ORS 750.055 because of its amendment by this Act. [1987 c.411 §7]

**ORS 743.691 Reimbursement for mastectomy-related services.** (1) All insurers offering a health benefit plan as defined in ORS 743.730 shall provide payment, coverage or reimbursement for the following mastectomy-related services as determined by the attending physician and enrollee to be part of the enrollee's course or plan of treatment:

(a) All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses;

(d) Treatment of physical complications of the mastectomy, including lymphedemas; and

(e) Inpatient care related to the mastectomy and post-mastectomy services.

(2) An insurer providing coverage under subsection (1) of this section shall provide written notice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and annually thereafter.

(3) A health benefit plan must provide a single determination of prior authorization for all mastectomy-related services covered under subsection (1) of this section that are part of the enrollee's course or plan of treatment.

(4) When an enrollee requests an external review of an adverse decision by the insurer regarding services described in subsection (1) of this section, the insurer must expedite the enrollee's case pursuant to ORS 743.857 (4).

**ORS 743.691 Continued**

(5) The coverage required under subsection (1) of this section is subject to the same terms and conditions in the plan that apply to other benefits under the plan.
(6) This section is exempt from ORS 743.700. [2003 c.748 §2]

This new statute replaces the requirement that the Federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277 be incorporated into Oregon group health insurance. This requirement had been in two group statutes, ORS 743.737 (15) that applied to small employer health benefit plans and ORS 743.754 (9) that applied to group health benefit plans. Both these group references and the individual health insurance reference, in ORS 743.766 (9), were removed from Oregon Law by Chapter 748 Oregon Laws 2003 (HB 3624). As noted, this enactment created the Oregon statutory requirement that mastectomy services be covered. The section of each group statute, removed by the amendment, is included below.

> **ORS 743.737 Required provisions of small employer health benefit plans; renewability; notices required for discontinuation; premium rates; carrier disclosures; annual actuarial certification.** Health benefit plans covering small employers shall be subject to the following provisions:
>
> (15) All small employer health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277. [1991 c.916 §7; 1993 c.18 §161; 1993 c.649 §10; 1995 c.603 §§6,37; 1997 c.716 §§7,8; 1999 c.987 §10; 2001 c.943 §12]
>
> **ORS 743.754 Requirements for group health benefit plans and for discontinuation of plans.** The following requirements apply to all group health benefit plans covering two or more certificate holders:
>
> (9) All group health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277.

**ORS 743.693 Reimbursement for pregnancy and childbirth expenses.** All health benefit plans as defined in ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care, as defined by ORS 743.845, and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses and enrolled dependents. [1999 c.428 §2; 2001 c.104 §289]

Note: See 743.700.

The following labor statutes and rules, ORS 659A.029, ORS 659A.030, OAR 839-005-0021, and OAR 839-005-0026 are requirements employers must meet regarding pregnancy benefits when providing other health benefits.

**ORS 659A.029 "Because of sex" defined for ORS 659A.030.** For purposes of ORS 659A.030, the phrase "because of sex" includes, but is not limited to, because of pregnancy,

childbirth and related medical conditions or occurrences. Women affected by pregnancy, childbirth or related medical conditions or occurrences shall be treated the same for all employment-related purposes, **including receipt of benefits under fringe benefit programs, (Emphasis Added)** as other persons not so affected but similar in their ability or inability to work by reason of physical condition, and nothing in this section shall be interpreted to permit otherwise. [Formerly 659.029]

**ORS 659A.030 Discrimination because of race, religion, color, sex, national origin, marital status or age prohibited.** (1) It is an unlawful employment practice:

(a) For an employer, because of an individual's race, religion, color, sex, national origin, marital status or age if the individual is 18 years of age or older or because of the race, religion, color, sex, national origin, marital status or age of any other person with whom the individual associates, or because of a juvenile record, that has been expunged pursuant to ORS 419A.260 and 419A.262, of any individual, to refuse to hire or employ or to bar or discharge from employment such individual. However, discrimination is not an unlawful employment practice if such discrimination results from a bona fide occupational requirement reasonably necessary to the normal operation of the employer's business.

(b) For an employer, because of an individual's race, religion, color, sex, national origin, marital status or age if the individual is 18 years of age or older, or because of the race, religion, color, sex, national origin, marital status or age of any other person with whom the individual associates, or because of a juvenile record, that has been expunged pursuant to ORS 419A.260 and 419A.262, of any individual, to discriminate against such individual in compensation or in terms, conditions or privileges of employment.

(c) For a labor organization, because of an individual's race, religion, color, sex, national origin, marital status or age if the individual is 18 years of age or older or because of a juvenile record, that has been expunged pursuant to ORS 419A.260 and 419A.262, of any individual to exclude or to expel from its membership such individual or to discriminate in any way against any such individual or any other person.

(d) For any employer or employment agency to print or circulate or cause to be printed or circulated any statement, advertisement or publication, or to use any form of application for employment or to make any inquiry in connection with prospective employment which expresses directly or indirectly any limitation, specification or discrimination as to an individual's race, religion, color, sex, national origin, marital status or age if the individual is 18 years of age or older or on the basis of an expunged juvenile record, or any intent to make any such limitation, specification or discrimination, unless based upon a bona fide occupational qualification. But identifying employees according to race, religion, color, sex, national origin, marital status, or age does not violate this section unless the Commissioner of the Bureau of Labor and Industries, after a hearing conducted pursuant to ORS 659A.805, determines that such a designation expresses an intent to limit, specify or discriminate on the basis of race, religion, color, sex, national origin, marital status or age.

**ORS 659A.030 Continued**

(e) For an employment agency to classify or refer for employment, or to fail or refuse to refer for employment, or otherwise to discriminate against any individual:

(A) On the basis of the individual's race, color, national origin, sex, religion, marital status or age, if the individual is 18 years of age or older;

(B) Because of the race, color, national origin, sex, religion, marital status or age of any other person with whom the individual associates; or

(C) Because of a juvenile record, that has been expunged pursuant to ORS 419A.260 and 419A.262.

However, it is not an unlawful employment practice for an employment agency to classify or refer for employment any individual where such classification or referral results from a bona fide occupational requirement reasonably necessary to the normal operation of the employer's business.

(f) For any person to discharge, expel or otherwise discriminate against any other person because that other person has opposed any unlawful practice, or because that other person has filed a complaint, testified or assisted in any proceeding under this chapter or has attempted to do so.

(g) For any person, whether an employer or an employee, to aid, abet, incite, compel or coerce the doing of any of the acts forbidden under this chapter or to attempt to do so.

(2) The provisions of this section apply to an apprentice under ORS chapter 660, but the selection of an apprentice on the basis of the ability to complete the required apprenticeship training before attaining the age of 70 years is not an unlawful employment practice. The commissioner shall administer this section with respect to apprentices under ORS chapter 660 equally with regard to all employees and labor organizations.

(3) The compulsory retirement of employees required by law at any age is not an unlawful employment practice if lawful under federal law.

(4)(a) It is not an unlawful employment practice for an employer or labor organization to provide or make financial provision for child care services of a custodial or other nature to its employees or members who are responsible for a minor child.

(b) As used in this subsection, "responsible for a minor child" means having custody or legal guardianship of a minor child or acting in loco parentis to the child. [Formerly 659.030]

**OAR 839-005-0021**

Gender Discrimination

**(1) Employers are not required to treat all employees exactly the same, but are prohibited from using gender as the basis for employment decisions with regard to hiring, promotion or discharge; or in terms, conditions or privileges of employment such as benefits and compensation. (Emphasis Added)**

(2) Discrimination because of sex or gender includes sexual harassment, discrimination based on pregnancy, childbirth and medical conditions and occurrences related to pregnancy and childbirth.

(3) In very rare instances, gender may be a bona fide occupational qualification (BFOQ), as defined in OAR 839-005-0045.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.029 & ORS 659A.030
Hist.: BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02

**OAR 839-005-0026**

Protections and Rights Relating to Pregnancy

(1) Pregnant women are protected from sex discrimination in employment.

**(2) In judging the physical ability of an individual to work, pregnant women must be treated the same as males, non-pregnant females and other employees with off-the-job illnesses or injuries. (Emphasis Added)**

**(3) The statutes prohibit discrimination regarding employee and dependent spouse benefits for pregnancy when employee and dependent spouse benefits exist for other medical conditions. (Emphasis Added)**

(4) Women needing to be absent from work because of pregnancy or childbirth may have rights under the Oregon Family Leave Act, as provided in ORS 659A.150 to 659A.186 and OAR 839-009-0200 to 839-009-0320.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.029, ORS 659A.030 & ORS 659A.150 - ORS 659A.186
Hist.: BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02

**ORS 743.694 Reimbursement for diabetes self-management programs.** (1) Subject to other terms, conditions and benefits in the plan, group health benefit plans as described in ORS 743.730 shall provide payment, coverage or reimbursement for supplies, equipment and diabetes self-management programs associated with the treatment of insulin-dependent

diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes prescribed by a health care professional legally authorized to prescribe such items.

(2) As used in this section, "diabetes self-management program" means one program of assessment and training after diagnosis and no more than three hours per year of assessment and training upon a material change of condition, medication or treatment that is provided by:

(a) An education program credentialed or accredited by a state or national entity accrediting such programs; or

(b) A program provided by a physician licensed under ORS chapter 677, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes. [2001 c.742 §2]

Note: See 743.700.

**ORS 743.695 Definition for ORS 743.697.** As used in ORS 743.697, "peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability. "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers. [1997 c.573 §2]

**ORS 743.697 Coverage of particular drugs.** (1) No insurance policy or contract providing coverage for a prescription drug to a resident of this state shall exclude coverage of that drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if the Health Resources Commission determines that the drug is recognized as effective for the treatment of that indication:

(a) In publications that the commission determines to be equivalent to:

(A) The American Hospital Formulary Services drug information;

(B) "Drug Facts and Comparisons" (Lippincott-Raven Publishers);

(C) The United States Pharmacopoeia drug information; or

(D) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;

(b) In the majority of relevant peer-reviewed medical literature; or

(c) By the United States Secretary of Health and Human Services.

**ORS 743.697 Continued**

(2) Required coverage of a prescription drug under this section shall include coverage for medically necessary services associated with the administration of that drug.

(3) Nothing in this section requires coverage for any prescription drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

(4) Nothing in this section requires coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration.

(5) This section is exempt from ORS 743.700. [1997 c.573 §3]

**ORS 743.699 Coverage of emergency services.** (1) All insurers offering a health benefit plan shall provide coverage without prior authorization for:

(a) Emergency medical screening exams;

(b) Stabilization of an emergency medical condition; and

(c) Emergency services provided by a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a participating provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) All insurers described in subsection (1) of this section shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(3) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and shall not deny coverage for emergency services solely because 9-1-1 was used.

(4) This section is exempt from ORS 743.700. [1997 c.651 §2; 2003 c.137 §1]

Note: ORS 743.699 is repealed on October 4, 2009. See section 2, chapter 137, Oregon Laws 2003

Note: See definitions in 743.801

**ORS 743.700 Automatic repeal of certain statutes on individual and group health insurance.** (1) Any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, shall stand repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise.

**ORS 743.700 Continued**

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section shall not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute shall apply to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer. [Formerly 743.145]

**ORS 743.701 Reimbursement for services performed by state hospital or state approved program.** No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program. [Formerly 743.116]

The next two statutes constitute a single provider mandate. The first statute, ORS 743.703, dealing with optometrists, applies only to insurers. The second statute, ORS 750.065, also dealing with optometrists, applies only to health care service contractors

**ORS 743.703 Reimbursement for services of optometrist.** (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967. [Formerly 743.117]

**ORS 750.065 Reimbursement for services performed by optometrists.** (1) Notwithstanding any provision of contract or agreement entered into by a corporation, association, society, firm, partnership or individual doing business as a hospital association or as a health care service contractor, whenever such contract or agreement provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such contract or agreement shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist. Unless such contract or agreement shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) Nothing in subsection (1) of this section shall apply to any contract or agreement limited to the furnishing of services to be performed exclusively by members of the association, society, group or partnership issuing such contract or agreement. [1971 c.97 §2]

**ORS 743.706 Reimbursement for maxillofacial prosthetic services.** (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section 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.

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982. [Formerly 743.119]

**ORS 743.707 Health insurance coverage for newly born and adopted children.** (1) All individual and group health insurance policies providing hospital, medical or surgical expense benefits that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

**ORS 743.707 Continued**

(a) A newly born child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.

(2) The coverage of newly born and adopted children required by subsection (1) of this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished the insurer within 31 days after the date of birth or date of placement in order to have the coverage extended beyond the 31-day period.

(4) The following requirements apply to coverage of an adopted child required by subsection (1)(b) of this section:

(a) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(b) A policy may not restrict coverage of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(5) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743.700 do not apply to this section. [Formerly 743.120; 1991 c.674 §2; 1995 c.506 §10]

**ORS 743.709 Reimbursement for services provided by psychologist.** Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to the insured or on the insured's behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150. [Formerly 743.123]

**ORS 743.710 Denial or cancellation of health insurance because of use by mother of diethylstilbestrol.** No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth. [Formerly 743.125]

**ORS 743.712 Reimbursement for services of nurse practitioner.** (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act. [Formerly 743.128]

**ORS 743.713 Reimbursement for services of denturist.** Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist as defined in ORS 680.500. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest. [Formerly 743.132; 1993 c.142 §15]

Note: 743.713 was added to and made a part of the Insurance Code by the people in the exercise of their initiative power but was not added to or made a part of ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

**ORS 743.714 Reimbursement for services of clinical social worker.** Whenever any individual or group health insurance policy or blanket health insurance policy described in ORS 743.534 (3) provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker licensed under ORS 675.510 to 675.600:

(1) The insured under the policy shall be entitled to the services of a clinical social worker licensed under ORS 675.510 to 675.600, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served. [Formerly 743.135]

**ORS 743.717 Tourette Syndrome; reimbursement for treatment.** For purpose of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed. [Formerly 743.143]

Note: See 743.700.

**ORS 743.718 Method of payments for ambulance care and transportation.** Any insurance policy issued or issued for delivery in this state that provides coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless the policy provides for direct payment to the provider. [Formerly 743.147]

**ORS 743.719 Reimbursement for certain surgical services performed by dentists.** Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable. [Formerly 743.052]

**ORS 743.721 Nondiscriminatory health insurance coverage for women.** Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives. [Formerly 743.037]

**ORS 743.722 Reimbursement for acupuncturist.** (1) Whenever any individual or group health insurance policy provides for payment or reimbursement for acupuncture services performed by a physician, the policy also shall pay or reimburse the insured for acupuncture services performed by an acupuncturist licensed under ORS 677.757 to 677.770. The

**ORS 743.722 Continued**

payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician or an acupuncturist, according to the customary and usual fee of acupuncturists in the area served.

(2)(a) Subsection (1) of this section does not require the employment of acupuncturists licensed under ORS 677.757 to 677.770 by group practice health maintenance organizations that are federally qualified pursuant to Title XIII subchapter XI of the Public Health Service Act (42 U.S.C. 300e et seq.).

(b) When a group practice health maintenance organization reimburses its members for acupuncture services performed by physicians outside its employ, it shall also reimburse its members for acupuncture services performed by an acupuncturist. [1989 c.832 §2; 1991 c.314 §3; 1995 c.79 §365]

Note: See 743.700.

**ORS 743.725 Claim submitted physician assistant.** (1) No insurer shall refuse a claim solely on the ground that the claim was submitted by a physician assistant practicing under the circumstances set forth in ORS 677.515 (4) rather than by the supervising physician for the physician assistant.
(2) This section is exempt from ORS 743.700. [1997 c.695 §3 (enacted in lieu 743.724); 2003 c.446 §1]

Note: 743.725 is repealed on October 4, 2009. See section 2, chapter 446, Oregon Laws 2003.

**ORS 743.726 Reimbursement for inborn errors of metabolism.** (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall include coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

(2) As used in this section, 'medical foods' means foods that are formulated to be consumed or administered enterally under the supervision of a physician, as defined in ORS 677.010, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis.

(3) This section is exempt from ORS 743.700. [1997 c.496 §2; 2003 c.263 §1]

Note: 743.726 is repealed on July 3, 2009. See section 2, chapter 263, Oregon Laws 2003.

**ORS 743.727 Reimbursement for mammo-grams; schedule of covered mammo-grams.** (1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage of mammograms as follows:

(a) Mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time upon referral of the woman's health care provider; and

(b) An annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health care provider.

(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the woman is determined by her health care provider to be at high risk for breast cancer. [1993 c.575 §2; 1999 c.429 §1]

Note: See 743.700.

**ORS 743.728 Reimbursement for pelvic examinations and Pap smear examinations; schedule of covered examinations.** All policies providing health insurance, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:

(1) Annually for women 18 to 64 years of age; and

(2) At any time upon referral of the woman's health care provider. [1993 c.576 §2; 1999 c.429 §2]

Note: See 743.700.

**ORS 743.729 Reimbursement for nonprescription enteral formula for home use; conditions.** (1) All policies providing health insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

(2) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas shall be no greater than those for any other treatment for the condition under the policy. [1993 c.407 §2]

Note: See 743.700.

Requirements of the Federal Newborns' and Mothers' Health Protection Act of 1996 have been incorporated into Oregon health insurance statutes in ORS 743.823. The statute is included below. OAR 836-053-1000 also requires compliance with this federal act. The administrative rule is also included.

**ORS 743.823 Enforcement of Newborns' and Mothers' Health Protection Act of 1996.** The Department of Consumer and Business Services shall enforce insurer compliance with the federal Newborns' and Mothers' Health Protection Act of 1996. [1997 c.343 §8]

**OAR 836-053-1000**

Statutory Authority and Implementation

(1) OAR 836-053-1000 to 836-053-1200 are adopted under the authority of ORS 731.244, 743.814, and 743.819, for the purpose of implementing ORS 743.699, 743.804, 743.807, 743.814, 743.817, 743.819, 743.821, 743.829, and 743.837. The filing and reporting requirements in this rule and in OAR 836-053-1070, 836-053-1130, 836-053-1170, and 836-053-1190 apply to all domestic insurers transacting health benefit plans, including health care service contractors, to all foreign carriers transacting health benefit plans who transacted $2 million or more in annual health benefit plan premium in Oregon, and to other carriers transacting health benefit plans as determined by the Director.

(2) When an insurer maintains more than one type of health benefit plan, the insurer shall comply with OAR 836-053-1000 to 836-053-1200 on a plan-by-plan basis.

(3) Not later than June 30 of each year, each insurer shall file with the Director for the immediately preceding calendar year the following information as required of the insurer:

(a) An annual summary relating to grievances and appeals, required by ORS 743.804(9) of all insurers;

(b) An annual summary relating to the insurer's utilization review policies, required by ORS 743.807(1) of each insurer that provides utilization review or has utilization review provided on its behalf;

(c) An annual summary relating to the insurer's quality assessment activities required by ORS 743.814(2) of each insurer that offers managed health insurance;

(d) The results of all publicly available federal Health Care Financing Administration reports and accreditation surveys by national accreditation organizations required by ORS 743.814(3)(a) of each insurer that offers managed health insurance;

(e) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer, required by ORS 743.814(3)(b) of each insurer that offers managed health insurance. The insurer may submit the summary required in this subsection in the format of the insurer's choosing,

including a summary prepared for another purpose. The summary required in this subsection shall include the following activities, to the extent the insurer engages in them, and may include any additional information that the insurer deems significant in describing its health promotion and disease prevention activities:

(A) Tobacco use and cessation;

(B) Cancer screening, including mammography;

(C) Diabetes education and home monitoring;

(D) Immunizations;

(E) Childbirth education and parenting support;

(F) Nutrition;

(G) Cardiovascular health; and

(H) Injury prevention; and

(f) An annual summary relating to the scope of the insurer's network and to the accessibility of services, required by ORS 743.817(1) of each insurer that offers managed health insurance.

(4) In order to minimize duplicative reporting requirements, an insurer may submit a copy of a report prepared for a national accreditation organization to meet the reporting requirements of section (3)(e) of this rule relating to the insurer's health promotion and disease prevention activities, OAR 836-053-1130(1) relating to the insurer's utilization review policies, OAR 836-053-1170(1) relating to the insurer's quality assessment activities and OAR 836-053-1190(1) relating to the insurer's provider network and the accessibility of services. To the extent that a report prepared for a national accreditation organization does not include information required by the department, the insurer must submit an addendum to the report that provides this information.

(5) If information required to be filed annually with the department pursuant to this rule has not changed since an insurer's previous annual filing, an insurer may satisfy the reporting requirements of this rule by indicating that the information has not changed, or if some but not all information has changed, by submitting an addendum to the previous annual filing indicating only the information that has changed since the previous filing. However, every third year the insurer must file all required information, including information that may not have changed since the previous filing. For example, if an insurer made an annual filing in 1998, it is sufficient to indicate in 1999 and 2000 that certain information has not changed since the previous annual filing or to submit an addendum indicating the information that has

**OAR 836-053-1000 Continued**

changed, but the filing in 2001 must contain all information required by the department pursuant to this rule.

(6) All filings required in section (3) of this rule must be made on computer disk.

(7) For purposes of OAR 836-053-1000 to 836-053-1200, "insurer" also includes a health care service contractor as defined in ORS 750.005 and a multiple employer welfare arrangement as defined in ORS 750.301.

(8) OAR 836-053-1000 to 836-053-1200 apply to a self-insured public entity to the extent provided in ORS 731.036.

(9) An insurer shall administer the plan in compliance with ORS 743.699, 743.804, 743.807, 743.814, 743.817, 743.821, 743.829, and 743.837 and OAR 836-053-1000 to 836-053-1200.

(10) An insurer shall comply with the federal Newborns' and Mothers' Health Protection Act of 1996, as referred to in ORS 743.823 with respect to group health insurance plans and individual health insurance plans.

Stat. Auth.: ORS 731.244, ORS 743.814 & ORS 743.819
Stats. Implemented: ORS 743.699, ORS 743.804, ORS 743.807, ORS 743.814, ORS 743.817, ORS 743.819, ORS 743.821, ORS 743.829 & ORS 743.837
Hist.: ID 1-1998, f. & cert. ef. 1-15-98; ID 5-2000, f. & cert. ef. 5-11-00

**ORS 743.842 Emergency eye care services without referral from primary care provider.** (1) As used in this section:

(a) "Eye care practitioner" means an optometrist or ophthalmologist licensed by the State of Oregon.

(b) "Eye care services" means health care services related to the care of the eye and related structures as specified by a health benefit plan.

(c) "Health benefit plan" has the meaning provided for that term in ORS 743.730.

(2) Any insurer that offers a health benefit plan that provides coverage of eye care services shall allow any enrollee to receive covered eye care services on an emergency basis without first receiving a referral or prior authorization from a primary care provider. However, an insurer may require the enrollee to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures. Nothing in this subsection shall be construed to require that covered eye care services rendered by an eye care practitioner on an emergency basis be furnished in a hospital or similar medical facility.

(3) An insurer described in subsection (2) of this section may not:

**ORS 743.842 Continued**

(a) Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other medical services under the health benefit plan.

(b) Require an eye care practitioner to hold hospital privileges as a condition of participation as a provider in the health benefit plan.

(4) Nothing in this section:

(a) Requires an insurer to provide coverage or reimbursement of eye care services;

(b) Requires an insurer to provide coverage or reimbursement of refractive surgery, ophthalmic materials, lenses, eyeglasses or other appurtenances; or

(c) Prevents an enrollee from receiving eye care or other covered services from the enrollee's primary care provider in accordance with the terms of the enrollee's health benefit plan.

(5) This section is exempt from ORS 743.700. [1999 c.749 §2]

Both Oregon insurance law and labor law require that children be provided access to group health insurance. ORS 743.847, ORS 659.830 and ORS 659.835 are included below.

**ORS 743.847 Medicaid not considered in coverage eligibility determination; state acquires right of individual to payment; prohibited ground for denial of enrollment of child; insurer duties.** (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means the issuer of any individual, franchise, group or blanket health policy or certificate or of any stop-loss or excess insurance issued in relation to a plan of a self-insured employer.

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer shall not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

**ORS 743.847 Continued**

(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.

(5) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with subsection (6) of this section directly to the custodial parent, the provider or the state Medicaid agency.

(6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(8) The provisions of ORS 743.700 do not apply to this section. [Formerly 743.816]

**659.830 Prohibition on limiting coverage under employee benefit plan based on eligibility to receive benefits under Title XIX of Social Security Act; prohibitions on limiting coverage under group health plans; requirements for group health plans.** (1) No employee benefit plan may include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan because that individual is provided, or is eligible for, benefits or services pursuant to a plan under Title XIX of the Social Security Act. This section applies to employee benefit plans, whether sponsored by an employer or a labor union.

(2) A group health plan is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. 1396a (section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) A group health plan shall not deny enrollment of a child under the health plan of the child's parent on the grounds 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 group health plan service area.

(5) Where a child has health coverage through a group health plan of a noncustodial parent, the group health plan shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with paragraph (b) of this subsection directly to the custodial parent, the provider or the state Medicaid agency.

(6) Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the group health plan shall be required:

**ORS 759.830 Continued**

(a) To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not to disenroll or eliminate coverage of the child unless the group health plan is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(7) A group health plan may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from such plan, that are different from requirements applicable to an agent or assignee of any other individual so covered.

(8)(a) In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(b) A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(9) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(b) "Group health plan" means a group health plan as defined in 29 U.S.C. 1167.

(c) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations. [Formerly 659.322]

**ORS 659.835 Health insurance coverage for children of employees.** Where a parent is required by a court or administrative order to provide health coverage that is available through an employer doing business in this state, the employer shall:

(1) Permit the parent to enroll under family coverage a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(2) If the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program.

(3) Not disenroll or eliminate coverage of a child unless the employer is provided satisfactory written evidence that:

(a) The court order is no longer in effect;

(b) The child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(c) The employer has eliminated family health coverage for all of its employees.

(4) Withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and pay this amount to the insurance provider. [Formerly 659.324]

MEASURE: HB2913-HB3444-SB1
EXHIBIT: A
HOUSE HEALTH & HUMAN SERVICES
DATE: 5-20-05 PAGES: 2
SUBMITTED BY: Staff

Oregon
Psychological
Association

Testimony before the House Health and Human Services Committee
Oregon State Legislature

May 20, 2005

Chairman Dalto and members of the committee:

My name is Robert Lundblad, Ph.D., I am a psychologist resident and I practice at the Oregon State Hospital.

I am testifying today on behalf of the OPA Board of Directors, which has voted to support Mental Health Parity as it is represented in Senate Bill 1, House Bill 3444 and House Bill 2319. OPA is the primary professional association for psychologists in Oregon with 825 members spread throughout the state. Our members will be in a better position to serve your constituents should you decide to pass this comprehensive mental health parity legislation.

I would also like to point out that the Governor's Mental Health Task Force made comprehensive mental health and substance abuse parity the highest priority recommendation for this legislative session. This is because patients who receive private insurance-covered treatment must be picked up by the public sector once they have exhausted the statutory allowed limits of their private insurance benefits.

Mental health parity, as provided for in these bills, puts mental illness and physical illness on an equal footing in health care plans. With parity, a health insurance carrier could not place limits – dollar, duration or lifetime – on mental health care, unless the same limit is placed on physical health care.

Twenty states have passed some degree of mental health parity legislation. The Public Employees' Benefit Board has also enacted parity with no significant cost increase. Federal government employees also have mental health parity in their insurance benefit.

Typically, health insurers have placed dollar or visit limits on mental illness. Oregon law currently requires insurers to cover the treatment of mental illness, but allows them to limit the amount of coverage.

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A statewide parity requirement creates a level playing field for all insurers and allows for an appropriate spreading of risks across a large population. SB 1 is the only real option that will accomplish the objective of improved mental health and substance abuse coverage with minimum cost increase.

An actuarial study completed at the request of the Oregon Psychological Association indicates that comprehensive mental health parity can be implemented in the state of Oregon with cost increases of approximately 1.2% or $1.27 per member per month in 1999 dollars. This is assuming that appropriate steps will be taken to manage the benefit, as has occurred with policies for state and federal employees.

Some will suggest a limited and diagnosis-based parity as a more affordable "half-a-loaf" approach. This would perpetuate discrimination against individuals with other diagnoses. It is the individuals with <u>severe</u> symptoms of <u>any</u> diagnosis who will be benefiting from this legislation should you choose to vote it into law.

Comprehensive Mental Health Parity saves money, families and lives.

MEASURE: SB 1
EXHIBIT: A
SENATE HEALTH POLICY
DATE: 3-9-05 PAGES: 2
SUBMITTED BY: Senator Courtney

PETER COURTNEY

President of the Senate

# SENATE COMMITTEE ON HEALTH POLICY

**SENATOR LAURIE MONNES ANDERSON, CHAIR**
**SENATOR JEFF KRUSE, VICE-CHAIR**
**SENATOR PETER COURTNEY**
**SENATOR GARY GEORGE**
**SENATOR BILL MORRISETTE**

*TESTIMONY BY SENATOR PETER COURTNEY*
*SUPPORTING SB 1*
*MARCH 9, 2005*

Chair Monnes Anderson, Vice-Chair Kruse, and members of the Committee, good afternoon. It has been a privilege to serve on this committee with you this session, and it is a privilege to appear before you as a witness to introduce for your consideration Senate Bill 1.

Like all of you, I am frequently asked about my legislative priorities for this session. I talk a lot about trying to solve our budget crisis and stabilizing funding for schools. This session I also have prioritized bills to require PE in schools, improve our state's readiness for natural disasters such as earthquakes, and contain the spiraling costs of healthcare. But when I am asked about my number one legislative priority, I answer without hesitation. It is Senate Bill 1.

In recent years our society has made great strides in our understanding of mental health. Unfortunately, while we now *speak* of the mentally ill with compassion, our state is far behind the times in how we deal with our own mentally ill population. Our programs are inadequate; our facilities are inhumane. I am haunted by what I saw when I toured the Oregon State Hospital last year. The decrepit condition of that facility represents a moral failure on the part of all of us.

We have a lot of work to do in Oregon to bring our facilities and treatment capacity into the 21st century. Fortunately, I am sensing that the Legislature's readiness to tackle this issue is greater than ever before, and gaining momentum. Today we take up one aspect of that task. Senate Bill 1 is about parity—equality—for those suffering from mental illness in our state. It is a simple bill. It would require health insurers to extend coverage for mental health conditions on the same terms that apply to physical health conditions.

35 states already do this in some form. Oregon does not. In Oregon, a patient with diabetes can receive the entire recommended course of treatment, and her private insurer will pay. A patient with a crippling bipolar disorder, on the other hand, may be told that she is entitled to ten doctor visits over her lifetime. After that, she is left with no coverage. She will either incur enormous medical bills, land in our over-burdened public system, or simply go untreated, where her illness may then manifest itself in physical ailments which, of course, would be covered, often at much greater expense. This defies logic, economics, and compassion. Perhaps this is why 35 other states have decided to do things differently.

I am not a healthcare expert. I know that the problems with our healthcare system are numerous and that this bill is not the solution to all of them. But I offer this bill because I think it should be part of the solution. There are plenty of experts here today who can answer your questions, provide you with statistics and data, and speak with much greater understanding of what we are doing wrong and how we need to fix it.

I hope that I am introducing Senate Bill 1 for the last time. I look forward to hearing the remaining testimony today, and I request your strong support for this bill.

Thank you.

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# Oregon

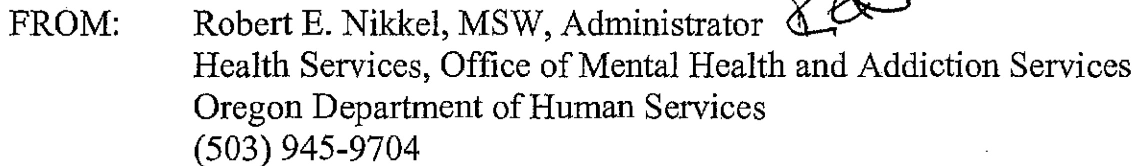
Theodore R. Kulongoski, Governor

**Department of Human Services**
**Health Services**
*Office of Mental Health & Addiction Services*
500 Summer Street NE E86
Salem, OR 97301-1118
Voice 503-945-5763
Fax 503-378-8467

March 9, 2005

MEASURE: SB 1
EXHIBIT: D
SENATE HEALTH POLICY
DATE: 3-9-05 PAGES: 3
SUBMITTED BY: Robert E. Nikkel

TO: The Honorable Laurie Monnes Anderson, Chair
Senate Health Policy Committee



FROM: Robert E. Nikkel, MSW, Administrator
Health Services, Office of Mental Health and Addiction Services
Oregon Department of Human Services
(503) 945-9704

SUBJECT: SB 1, Prohibits Group Health Insurers from imposing treatment or payment limitations for mental health and chemical dependency treatment services

Chair Monnes Anderson and members of the committee:

My name is Bob Nikkel, Administrator of the Office of Mental Health and Addiction Services, Department of Human Services. I am here to testify in support of SB 1, which would prohibit group health insurers from imposing financial or treatment limitations on coverage for mental health and chemical dependency treatment services unless similar limitations are imposed on coverage of other medical conditions.

Senate Bill 1 would correct the disparity that allows commercial insurance coverage for behavioral health conditions to be markedly less than that for other medical conditions. Failure to provide medically necessary care for mental health and addictive disorders costs employers and the public much more than the cost of the care itself. Denial of such care is not justified in either clinical or economic terms. The fiscal impact of this bill on the private sector would be negligible while providing employees with coverage for conditions that respond well to early and appropriate treatment.

Consider the following facts:

1. **Untreated Mental Illness Is Costly.** Schizophrenia, depression, anxiety disorders, and chemical dependency (including alcoholism) carry burdens of disease (meaning combined direct health care costs and indirect costs) that are among the highest of all health care conditions. Lack of parity coverage costs

   businesses in the United States over $70 billion annually in lost productivity, use of disability/sick leave, and increased use of other health services. Depressed workers have more absenteeism and short-term disability days. Reducing mental health benefits has been shown to increase costs to businesses. It is well established that patients who are suffering from mental health and addictive disorders are sometimes reluctant to acknowledge and seek treatment for these conditions. When the additional hurdle of inadequate insurance coverage complicates the picture, such persons and their families suffer the psychological, health, social, and economic consequences of these treatable conditions much longer and with greater residual effects.
2. **We Have a Good and Growing Knowledge Base.** Diagnostic science and treatment outcomes for most mental health and chemical dependency disorders are better studied and more effective than for most other medical conditions.
3. **Mental Illnesses Are Common.** The Surgeon General has confirmed that 18-20% of population may be affected by a mental disorder, more than 25% when addictive disorders are included. In most primary care practices, more than 30% of patients have mental or chemical dependency conditions that are a major focus of treatment.
4. **Costs of Parity Are Negligible.** Under current parity initiatives in other states, costs and premiums have either dropped or only increased slightly. Projections of the fiscal impact of the proposed federal parity bill are premium increases of less than 1%. The Public Employees' Benefit Board's experience with parity has resulted in a premium increase of only 0.4%.
5. **Treatment Works, But Barriers Are Significant.** President Bush's New Freedom Commission on Mental Health clearly identified that most mental health conditions have effective and cost-effective treatments. According to the landmark Mental Health Report of the Surgeon General in 2000, "The mental health field is plagued by disparities in the availability of and access to its services. A key disparity often hinges on a person's financial status: formidable financial barriers block off needed mental health benefits from too many people."

6. **Parity Is Fair for Patients and Providers.** The health plan or provider makes medical necessity and service limit determinations. Patients with mental and addictive disorders receive appropriate treatment as they would with other significant illnesses.
7. **Arguments Against Parity are Based On Misunderstandings.** The diagnostic system for these illnesses is accurate and effective. Treatment guidelines are effective and reflect no greater variation than other areas of medicine. Treatment of symptoms when the cause is unclear is a valid and common practice, just as it is throughout all other areas of medicine.
8. **Most Other States Have Already Enacted Parity Laws.** Thirty-five other states have parity laws of varying scope and coverage. None have been repealed and many have been expanded. Oregon's reputation as an innovative pioneer in relation to social and health policy does not yet apply to insurance for persons with mental health and chemical dependency conditions.

In summary, SB 1 would provide necessary mental health and chemical dependency coverage to the vast majority of Oregonians who have group health insurance without excessive costs to employers or the public. There would be no appreciable public costs or savings derived from this legislation. However, there would certainly be reduction over time in the overwhelming demands placed on the public mental health delivery system. This would allow some patients to continue to receive treatment from private sector providers and for the public sector to more effectively implement preventive and earlier interventions for serious psychiatric disorders.

Society's understanding of mental and addictive illness has never been greater. These illnesses exact a terrible toll on patients and the economy. Evidence-based treatments for most of these conditions work well and have positive outcomes. Many providers, consumers and advocates believe it is now time for science to triumph over stigma and ignorance and to end what they experience as insurance discrimination.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

LISA A. MCHENRY,

Plaintiff,

v.

PACIFICSOURCE HEALTH PLANS and THE METRO AREA COLLECTION SERVICE, INC. GROUP HEALTH/DENTAL PLAN,

Defendants.

CV-08-562-ST

OPINION AND ORDER

STEWART, Magistrate Judge:

## INTRODUCTION

Plaintiff, Lisa A. McHenry ("McHenry"), is a participant in the Metro Area Collection Service, Inc. Group Health/Dental Plan, which is insured by defendant, PacificSource Health Plans ("PacificSource"). McHenry's minor son, J.M., suffers from autism and receives Applied Behavioral Analysis ("ABA") therapy. This therapy has been effective in treating J.M.'s autism

but at a substantial cost. PacificSource is the claims administrator and has denied coverage for J.M.'s ABA therapy. McHenry brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 USC §§ 1001-1461, to compel coverage.

On May 5, 2009, this court ruled that because the Plan did not unambiguously grant PacificSource the power to determine eligibility, interpret Plan language, or making binding benefits determinations, the *de novo* standard of review applies to PacificSource's denial of benefits (docket #27).

The parties have filed cross motions for summary judgment (dockets #41 & #47). All parties have consented to allow a Magistrate Judge to enter final orders and judgment in this case in accordance with FRCP 73 and 28 USC § 636(c). For the reasons set fourth below, McHenry's motion is denied and defendants' motion is granted.

## UNDISPUTED FACTS

J.M. was diagnosed with autism in May 2006, at the age of one year and nine months. On or about November 20, 2006, J.M.'s pediatrician, Rupa K. Shah, M.D., submitted to PacificSource a request for coverage for ABA therapy. J.M. began receiving ABA therapy from Emily Hoyt, a Board Certified Behavior Analyst ("BCBA"), in January 2007. Hoyt submitted invoices to PacificSource for payment of services provided to J.M. from January through April 2007. SR 16-18.[1]

In June 2007, PacificSource denied payment of these billings, explaining that the "[p]rovider is not eligible on this plan." SR 16. Later that same month, McHenry submitted to PacificSource an Initial Grievance of the denial. SR 20. In her grievance she inquired "what

[1] "SR" refers to the stipulated record filed by the parties on May 22, 2009 (docket #46).

would make a therapist eligible to provide [ABA therapy] on our plan[?]" and whether PacificSource "offer[ed] a plan that include[d] ABA therapy?" *Id*. She requested that her claim receive a medical, not administrative, review.

PacificSource submitted McHenry's grievance to its Medical Grievance Review Committee ("Grievance Committee"). SR 50-53. On August 2, 2007, the Grievance Committee notified McHenry that it had upheld PacificSource's denial of her claim on three bases: (1) the Plan "specifically exclude[d] coverage for experimental or investigational procedures, services and treatments;" (2) "the plan exclude[d] academic or social skills training;" and (3) BCBAs, "while professionally educated, are not medically trained clinicians and are not eligible providers for PacificSource." SR 54. It then explained:

> This determination is based on the above exclusions and a lack of sufficient evidence-based peer-reviewed literature and other supporting data to establish this as a standard of care of coverage. The committee determined that Applied Behavior Analysis meets the plan definition of an experimental or investigational procedure.

*Id*.

McHenry appealed this decision on August 6, 2007. SR 70-71. She disagreed with the conclusion that ABA therapy was experimental or investigational in nature and cited to an article listing the many medical professionals, medical organizations, and government agencies that had accepted it as a scientifically based treatment for children with autism. SR 70, 72-77 (Erick V. Larsson, Ph.D., *Intensive Early Intervention using Behavior Therapy is No Longer Experimental*, *available at* http://rsaffran.tripod.com/ieibt.html) (last accessed Jan. 5, 2010).[2]

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[2] The stipulated record contains many articles from scientific and academic journals, government publications, websites, and other sources which McHenry submitted during the course of the administrative appeals process. These articles are cited by the page(s) on which they appear in the stipulated record and, if published, to the appropriate journal or publication. For government publications or other articles, a parallel citation to the website at which the article is available is given for the (continued...)

PacificSource submitted her appeal to its Policy and Procedures Review Committee ("Policy Committee"). SR 93. By letter dated August 28, 2007, the Policy Committee informed McHenry that it had upheld the denial, explaining that "[a]fter reviewing all of the available information in this case, the committee concluded that the services provided by ABA therapy are educationally based social/interactive skill training services" which were "specifically exclude[d]" by the Plan. *Id.* If McHenry believed any covered services were being provided "in adjunct to ABA therapy," she would need to submit those services for a payment decision, but to be covered, "eligible services would need to be provided by an eligible medical or mental health provider . . . ." *Id.*

On September 24, 2007, McHenry submitted her written appeal of the Policy Committee's decision, disputing the conclusion that ABA therapy was primarily educational or social skills training. SR 108. She noted that while some of the results of the therapy included improvement in educational and social skills, "ABA therapy programs include speech and several hundreds of other therapeutic goals that are **essential activities of everyday life.**" *Id* (emphasis in original). She compared the focus and improvement of everyday activities provided by ABA therapy to that provided by therapy for an orthopedic disability. *Id.* Additionally, she submitted letters in support of her claim from Dr. Shah and from Karen Grant, Psy.D., a psychologist with the Oregon Health Sciences University, Child Development and Rehabilitation Center Autism Clinic. SR 109-12.

PacificSource acknowledged McHenry's appeal by letter October 1, 2007, and informed her that the next and final level of PacificSource's internal review process was a hearing before

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[2](...continued)
reader's convenience to the extent practicable.

the Membership Rights Panel ("MRP"). SR 196. McHenry appeared before the MRP on November 7, 2007. SR 219, 350. She presented testimony and documents which she believed refuted each of the three bases that had been cited for denying her claim at the three previous levels of review. SR 224-347.

On November 21, 2007, PacificSource notifed McHenry of the MRP's conclusion that ABA therapy was "behavioral-educational social skill training" specifically excluded by the Plan. SR 351. It also informed her that she could request an independent external review. *Id.*

McHenry requested that review, and PacificSource randomly selected Independent Medical Expert Consulting Services, Inc. ("IMEDICS") to conduct it. SR 368. On December 12, 2007, IMEDECS notified McHenry that because her dispute did not involve an adverse determination based on medical necessity, experimental or investigational treatment, or continuity of care, Oregon external review law did not apply, and it would conduct no review. SR 381.

Having exhausted her remedies with PacificSource, McHenry filed this lawsuit on May 5, 2009.

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**STANDARDS**

The parties have filed motions for summary judgment pursuant to FRCP 56. However, it is clear from the parties' briefing that they desire the court to issue final judgment based upon the stipulated record and the additional evidence submitted with their supporting memoranda. In

an ERISA case, under the *de novo* standard of review, "[t]he court simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits." *Abatie v. Alta Health & Life Ins. Co.*, 458 F3d 955, 963 (9th Cir 2006) (*en banc*). In conducting this review the court "can evaluate the persuasiveness of conflicting testimony and decide which is more likely true." *Kearney v. Standard Ins. Co.*, 175 F3d 1084, 1095 (9th Cir 1999) (*en banc*), *cert denied*, 528 US 964 (1999). Moreover, given the nature of the issues in this case, to rule in favor of either party, this court must make factual findings by weighing the evidence in the record. Accordingly, FRCP 56, with its "genuine issue of material fact" standard, is inappropriate. *See id.* Instead, the proper procedural mechanism is a motion for judgment on the record pursuant to FRCP 52. *See Thompson v. Ins. and Benefits Trust*, ___ F Supp2d ___, 2009 WL 3246859, at *1 (ED Cal Sept. 30, 2009); *Rodgers v. Metro. Life Ins. Co.*, ___ F Supp2d ___, 2009 WL 2913477, at *4 (ND Cal Sept. 9, 2009). The court construes the parties' motions as being brought pursuant to FRCP 52 and will decide this matter based upon the evidence contained in the stipulated record and such other evidence it finds is clearly "necessary to conduct an adequate *de novo* review." *Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan*, 46 F3d 938, 944 (9th Cir 1995) (citation omitted).

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## DISCUSSION

### I. Background

#### A. Nature of Autism

Autism is a neurobiological disorder that affects a child's development by severely limiting his or her ability to interact with others. *See* SR 267-68 (Dep't of Defense*, Report and Plan on Services to Military Dependent Children with Autism* 5 (July 2007) ("*DOD Report*")). Federal regulations define autism as a "developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance." 34 CFR § 300.8(c)(1)(i).

Autism is part of the larger class of Pervasive Developmental Disorders ("PDD") or Autistic Spectrum Disorders ("ASD"), synonymous terms which refer to a continuum of related cognitive and neurobehavioral disorders "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities." Diagnostic and Statistical Manual of Mental Disorders 69 (4th ed. text revision 2000) ("DSM-IV-TR"); SR 931 (Pauline A. Filipek, *et al.*, *Intervention for Autistic Spectrum Disorders*, 3 NeuroRX 207, 207 (April 2006)). These conditions are present from birth or early in development and are typically diagnosed in early childhood. The cause of autism is unknown and may have "multiple etiologies that are currently grouped together under this diagnostic umbrella because of the similar core behavioral symptomatology." SR 931-32 (Filipek, *supra*, at 207-08).

As its physiological etiology is unknown, austism is diagnosed by the behavioral symptoms it causes. Specifically, diagnostic criteria for autism require the presence of six symptoms from three categories of behavior: impaired reciprocal social interaction, impaired communication, and restricted, repetitive, or stereotyped behaviors. DSM-IV-TR at 75. Examples of these symptoms can include a lack interest in establishing relationships,

obliviousness to others or their needs, lag in development of spoken language or language comprehension, and stereotyped body movements like clapping, finger flicking, rocking or swaying, or walking on tiptoes. *Id* at 70-71.

**B. <u>ABA Therapy</u>**

Autism has no known cure. Because its etiology is not fully understood, it is not surprising to find no etiology-based treatment methods. *See* SR 892 (Kostas Francis, *Autism Interventions: A Critical Update*, 47 Developmental Med. & Child Neurology 493 (2005)). Thus, many treatments focus primarily on addressing the developmental impairments caused by the disorder. *See* SR 903 (Patricia Howlin, *The Effectiveness of Interventions for Children with Autism*, J. Neural Transmission, Supplement 69, at 101 (2005)). ABA therapy is one such treatment.

"ABA describes a systematized process of collecting data on a child's behaviors and using a variety of behavioral conditioning techniques to teach and reinforce desired behaviors while extinguishing harmful or undesired behaviors. . . . Practically speaking, it is the application of behavioral principles to shape behaviors and teach new skills in an individual." SR 270 (*DOD Report* at 8). ABA is not unique to autism; its methods are derived from Skinnerian behavioral psychology and have been applied to community development, social work, nursing, industry, education, and medicine. *See* SR 1322 (Karola Dillenburger, *Parent Education and Home-Based Behavior Analytic Intervention: An Examination of Parents' Perceptions of Outcome*, 29 J. Intellectual & Developmental Disability (2004)). It was first studied and applied as a potential treatment methodology for autistic children by O. Ivar Lovaas at UCLA. *See* SR 991 (O. Ivar Lovaas, *Behavioral Treatment and Normal Educational and*

*Intellectual Functioning in Young Autistic Children*, 55 J. Consulting and Clinical Psychology 3 (1987)).

ABA employs "operant conditioning" and "discrete trial training" among other behavioral psychology techniques to teach basic life skills one small step at a time. Throughout the treatment, "the focus is on the use of rewards or reenforcement to encourage desired behaviours and the elimination or reduction of unwanted behaviours by removing their positive consequences by means of 'time out,' 'extinction,' or punishment." SR 894 (Francis, *supra*, at 495). As new skills are acquired, they are "generalized" into other settings with the intent that the child learns to employ that skill in a new situation and without the encouragements or "prompts" initially relied upon. Following these methods over a period of several years, Lovaas's study found that it was possible for some autistic children to acquire the skills needed to enter into and successfully complete first grade in an "ordinary" classroom unassisted. Over 40% of the participants in his experimental group were reportedly indistinguishable from non-autistic children.

Although Lovaas's methods and results are not without their critics, multiple studies over the past two decades have confirmed his findings that ABA is generally beneficial to children diagnosed with PDDs. *See*, *e.g.*, SR 979 (Glen O. Sallows & Tamlynn D. Graupner, *Intensive Behavioral Treatment for Children with Autism: Four-Year Outcome and Predictors*, 110 Am. J. on Mental Retardation 417 (2005)); SR 1209 (Howard Cohen, *et al.*, *Early Intensive Behavioral Treatment*: *Replication of the UCLA Model In A Community Setting*, 27 J. Developmental and Behavioral Pediatrics 145 (2006)); SR 1335 (Tristram Smith, *et al.*, *Intensive Behavioral Treatment for Preschoolers with Severe Mental Retardation and Pervasive*

*Developmental Disorder*, 102 Am. J. on Mental Retardation 238 (1997)); SR 1471 (Bob Remington, *et al.*, *Early Intensive Behavioral Intervention: Outcome for Children With Autism and Their Parents After Two Years*, 112 Am. J. on Mental Retardation 418 (2007)). Since Lovaas's study, ABA has expanded and grown as research has continued to test its efficacy in different populations and in clinical or non-clinical settings and practitioners have attempted to standardize best practices. *See* SR 1228-30 (Robert Horner, *et al.*, *Problem Behavior Interventions for Young Children with Autism: A Research Synthesis*, 32 J. Autism & Developmental Disorders 423, 424-26 (2002)).

While the degree of ABA's efficacy is the subject of current research and debate, "[d]ecades worth of scientific research provide clear and convincing support" for its use as an "effective intervention." SR 926 (William J. Barbaresi, *et al.*, *Autism: A Review of the State of the Science for Pediatric Primary Health Care Clinicians*, 160 Archives of Pediatrics & Adolescent Medicine 1167, 1171 (AMA 2006)). These studies indicate that ABA should be initiated at an early age, for a minimum of 20 to 40 hours a week, and for two to four years. *Id*; SR 996 (Lovass, *supra*); SR 1210 (Cohen, *supra*); SR 1252 (Svein Eikeseth, *et al.*, *Outcome for Children With Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7*, 31 Behavior Modification 264 (2007))

ABA therapy is costly and demands a substantial investment of a family's time and money. Family involvement is a critical component, and it is common for parents to be trained in its methods to continue its application at home. *See* SR 1252 (Eikeseth, *supra*). The financial cost of ABA therapy services in a clinical setting can easily reach as high as $50,000 per year. SR 979 (Sallows, *supra*, at 418).

A defining feature of ABA intervention is treatment directed by a professional with advanced formal training in behavioral analysis. Oregon has no certification procedure for these professionals. Shaw Decl., ¶ 2 & Ex. A. The nationally accredited certification agency, the Behavior Analyst Certification Board ("BACB"), provides a standardized certification as a BCBA. *See* SR 1061-64 (BACB, *Standards for Board Certified Behavior Analyst® (BCBA®)*, *available at* http://www.bacb.com/becom_frame.html) (last accessed Jan. 5, 2010). A BACB certification as a BCBA requires, at a minimum, a masters degree and several hundred hours of graduate level instruction or mentored or supervised experience with another BCBA. Additionally, multiple universities throughout the United States provide advanced degree programs in ABA therapy which involve a combination of course work and practical experience.

**C. <u>ABA Therapy Provided to J.M.</u>**

J.M. began receiving ABA therapy from Hoyt in January 2007. Hoyt received her Masters Degree in Behavior Disorders/ABA from Columbia University in New York. SR 187. She is a certified BCBA and has worked with autistic children since 1998. *Id*; SR 1188.

Hoyt provides ABA therapy through Building Bridges, a clinic in southeast Portland. SR 187. Its services include "comprehensive home programs for young children on the autism spectrum." SR 188. Each child is given an individual assessment and a plan specifically tailored to his or her needs. The ABA therapy is targeted at the child's communication, cognitive skills, academics, social skills, lay skills, and self-help and fine motor skills. Treatment is provided in home through two-hour, one-on-one sessions with a therapist, and multiple sessions a day are

recommended. Parents are trained in the techniques used by the therapist in order to apply the elements of the treatment to daily interactions with their child. *Id*.

According to McHenry, J.M. has benefitted greatly from the ABA therapy provided by Hoyt. SR 1159.

**D. <u>Coverage for Autism Under the Plan</u>**

At the time McHenry began seeking services for J.M., the Plan dated November 1, 2006 ("2006 Plan"), specifically excluded benefits for PDDs. SR 1732. It did, however, provide benefits for services related to conditions which may be symptoms of autism, such as speech, physical, and occupational therapy. SR 1717-18. PacificSource paid benefits for treatment J.M. received along these lines in early 2007, prior to the Plan's annual renewal date of November 1, 2007. SR 14-15. PacificSource never cited the pervasive developmental disorder exclusion in its denials of reimbursement for J.M.'s ABA therapy.

The status of this exclusion was brought into question by legislation effective shortly after J.M.'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).[3] 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.

[3] ORS 743.556 was renumbered as ORS 743A.168 in 2007. The newer citation is used for ease of reference.

After its passage, PacificSource announced on its website that:

> [b]eginning January 1, 2007, PacificSource will be managing mental health and chemical dependency treatments consistent with the implementation of Oregon's new parity rules. We will apply utilization criteria and benefits for both mental health and chemical dependency in a manner similar to those applied to other medical benefits and treatment reviews.

SR 1745.

Pacific Source also provided a table of covered and non-covered diagnoses under the Parity Act and listed autism (299.0) as a covered mental health diagnosis. SR 1746. Accordingly, PacficSource provided coverage in its 2007 Plan effective November 1, 2007, for "medically necessary services for the treatment of mental and nervous conditions" including autism. SR 1747, 1778. As amended, the 2007 Plan offered coverage for autism in compliance with the Parity Act. However, it retained several exclusions at issue here.

## II. Preliminary Issues

As a threshold issue, PacificSource asserts that McHenry is not entitled to reimbursement for the ABA therapy provided to her son before November 1, 2007. McHenry admits that the 2007 Plan did not take effect until November 1, 2007, but argues that PacificSource was obligated to provide coverage when the Parity Act became law on January 1, 2007. Moreover, PacificSource expressed its intent to amend its policy language by stating on its website that it would be "managing mental health . . . treatments" in compliance with the Parity Act "beginning January 1, 2007." PacificSource's actions throughout 2007 repeatedly affirmed that intent. First, PacificSource explicitly relied on the 2007 Plan language in denying McHenry's claim at each level of review, though it was not technically operative until the time of her second appeal. SR 54-58, 93-97, 351. Second, throughout the course of processing McHenry's claim,

PacificSource employees routinely referenced the 2007 Plan, both internally (SR 89-92, 103-05, 199, 348-49, 390-91) and in communications with the Oregon Insurance Division regarding her claim (SR 94-97, 124, 394-95). Finally, McHenry argues that because PacificSource never relied on the 2006 Plan's exclusion for autism as a basis for denying her claims throughout her administrative appeals process, it is barred from doing so now.

ERISA requires an employee benefits plan to set forth the specific reasons for an adverse benefits determination at the time of its decision. 29 USC § 1133; 29 CFR § 2560.503-1(g); *see Booton v. Lockheed Med. Benefits Plan*, 110 F3d 1461, 1463 (9th Cir 1997) ("If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial[.]"). In view of this requirement, a plan administrator is not permitted to assert rationales during litigation that it "adduces only after the suit has commenced." *Jebian v. Hewlett-Packard Co. Employee Benefits Organization Income Protection Plan*, 349 F3d 1098, 1104 (9th Cir 2003), *cert denied*, 545 US 1139 (2005); *see also McCoy v. Fed. Ins. Co.*, 7 F Supp2d 1134, 1145 (ED Wash 1998) (defendant waived its right to raise an argument on *de novo* review where it had the opportunity to raise it during the ERISA review process but did not do so, and plaintiff did not acquiesce in defendant's raising of the issue)

PacificSource never cited the lack of autism coverage under the 2006 Plan as a reason for denying McHenry's claim during its administrative review. In fact, at every step of the review, it acted as if the 2006 Plan provided coverage and even cited language to McHenry from the 2007 Plan as the basis for its denial. This court declines to now entertain PacificSource's belated argument that autism was not a covered diagnosis prior to November 1, 2007.

## III. Analysis

To be entitled to reimbursement for J.M.'s treatment, the parties agree that ABA therapy must be medically necessary, a covered benefit under the Plan, and provided by an eligible provider. McHenry has the burden to prove that ABA therapy is a covered benefit under the Plan, and PacificSource has the burden to prove that it falls within an exclusion. *See Mario v. P&C Food Mkts, Inc.*, 313 F3d 758, 765 (2nd Cir 2002).

### A. Medically Necessary

J.M.'s pediatrician, Dr. Shah, has thrice written to PacificSource indicating that ABA treatment was medically necessary to treat J.M.'s autism. SR 1189-92. PacificSource has not challenged J.M.'s diagnosis or Dr. Shah's opinion that ABA is a medically necessary treatment. Therefore, she satisfies that requirement for coverage.

### B. Covered Benefit

Even if ABA therapy is medically necessary, PacificSource argues that it is not a covered benefit because it falls under the Plan's exclusions either for: (1) experimental or investigational procedures; (2) educational services; or (3) academic and social skills training.

#### 1. Experimental or Investigational Procedures

The Plan excludes services for "[e]xperimental or investigational procedures," defined, in part, as:

> Services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are, in PacificSource's judgment, experimental or investigational for the diagnosis and treatment of the patient. For purposes of this exclusion, experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures . . . or the use thereof which at the time they are rendered and for the purpose and in the manner they are being used: . . .

- Are not of generally accepted medical practice in the state of Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources; [or]
- Are not approved for reimbursement by the Centers for Medicare and Medicaid Services[.]

SR 1789.

**a. Standard of Review**

Despite this court's earlier ruling on the standard of review, PacificSource argues that its decision with respect to this exclusion is still entitled to deference because the 2007 Plan commits the determination of which "services" are experimental and investigational to "PacificSource's judgment." *Id.* It points out that other courts have interpreted this language to confer discretionary authority. *See Chambers v. Family Health Plan Corp.*, 100 F3d 818, 825 (10th Cir 1996) (plan language stating "medical [or] surgical . . . procedures . . . which in the judgment of [the insurer] are experimental" expressly gave insurer discretion to determine whether to deny a claimant insurance benefits for an "experimental" procedure); *Loyola Univ. of Chicago v. Humana Ins. Co.*, No. 89 C 7855, 1992 WL 80522, at *2 (ND Ill April 14, 1992), *aff'd*, 996 F2d 895 (7th Cir 1993). PacificSource also interprets this court's prior ruling as recognizing that it retains discretion on this narrow issue. *See* Opinion and Order (docket #27), p. 11.

Contrary to PacificSource's interpretation, this court's prior ruling did not find that PacificSource retains the discretion to decide whether the exclusion for experimental and investigational procedures is satisfied. Rather, it unambiguously stated that this language was not sufficient to notify a claimant that the Plan granted discretionary authority to PacificSource to determine claims. Absent this broad grant of discretion, the standard of review in the Ninth

Circuit is *de novo*, even where the Plan contains discretionary language as to one element of the Plan. "[A] plan will not sufficiently confer discretion sufficient to invoke review for abuse of discretion just because it includes a discretionary element. Rather, the power to apply that element must also be 'unambiguously retained' by the administrator." *Sandy v. Reliance Std. Life Ins. Co.*, 222 F3d 1202, 1204 (9th Cir 2000) (citation omitted).

**b. Generally Accepted Medical Practice**

PacificSource first argues that ABA therapy is experimental or investigational, as those terms are defined by the Plan, because it is not the generally accepted standard of care for autism in Oregon or anywhere else. In making this determination, PacificSource relied exclusively on the opinion of its Chief Medical Officer, Steven D. Marks, M.D., and offers his declaration explaining his rationale for finding that ABA therapy falls within this exclusion. McHenry objects to the admission of this declaration on the grounds that it is outside the administrative record.

This court has discretion to allow additional evidence not before the plan administrator, but should exercise this discretion "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Mongeluzo*, 46 F3d at 944 (citation omitted). One such circumstance is where a claim requires "consideration of complex medical questions or issues regarding the credibility of medical experts." *Opeta v. Nw. Airlines Pension Plan*, 484 F3d 1211, 1217 (9th Cir 2007) (citation and internal quotation marks omitted).

Dr. Marks is the sole expert relied upon by PacificSource for arguing that ABA therapy falls within one of the Plan's exceptions. He formulated PacificSource's autism policy,

including its rejection of ABA therapy as a covered benefit. His declaration is primarily a summary of his reasoning for choosing to reject ABA therapy based upon the Plan's exclusions. Considering the complexity of the medical issues in this case, McHenry's objection is overruled.

Dr. Marks states that in the course of developing the PacificSource policy to reject coverage for ABA therapy for autism (SR 25-29), he "read many articles and textbook chapters, along with doing some intensive internet searches to better understand the current state of treatment for autism." Marks Decl., (docket #50), ¶ 4. After considering all of these materials, he concluded that the "consensus of all that I read was that there was and is no cure for autism." *Id*. Rather, "each treatment modality had its supporters and its detractors[,] . . . there is no 'gold standard' for the treatment of autism, and there is much debate in the literature regarding the efficacy of any one approach, including ABA." *Id*. From his review of the literature and his own experience as a practitioner, "it became clear that ABA was not a well-proven or evidence-based standard of medical care, nor was it a standard of coverage within the industry." *Id*, ¶ 5.[4]

McHenry attacks Dr. Marks opinion on multiple fronts. First, she deems it irrelevant since he is not an expert in treating autism or other PDDs. Second, McHenry counters it with the opinion of Karen Grant, Psy.D. SR 110-12. Unlike Dr. Marks, Dr. Grant actively practices and does research in the field of autism treatment. She opines that based on "33 years of research[,] . . . ABA therapy is not only an empirically supported and validated treatment, but . . . is also a long standing treatment for individuals with autism," and cites to numerous articles to support her conclusion. SR 110-11. Third, McHenry cites a raft of scientific articles to contradict the

[4] A partial list of the sources Dr. Marks' relied upon in reaching his conclusion are appended to the PacificSource Health Service Procedure: Autism – Draft II, the development of which Dr. Marks' oversaw. Marks Aff., ¶ 8; SR 28-29. Dr. Marks represents that these sources included some articles that supported ABA therapy and some articles calling into question the validity of the studies used by supporters of ABA.

notion that ABA therapy is experimental or investigational. Fourth, McHenry points to numerous government and state agencies which have concluded that "ABA-based procedures represent best practices for individuals with autism . . . ." SR 968.[5] Fifth, McHenry notes that Dr. Marks has not been consistent in his position. Early on in the handling of J.M.'s claim, he indicated a favorable opinion of ABA therapy, stating "ideally I'd like to see these kids get into an ABA-type program that we could contract for on a case rate basis." SR 14. Finally, McHenry submits a recent external review obtained by the Oregon Insurance Division which concluded that ABA therapy was medically necessary for the treatment of autism and that denying ABA therapy was not consistent with national standards of care. SR 117-18.

Based upon a thorough examination of the record, this court concludes that the weight of the evidence demonstrates that ABA therapy is firmly supported by decades of research and application and is a well-established treatment modality of autism and other PDDs. It is not an experimental or investigational procedure. Dr. Grant's opinion corresponds with this court's overall impression of the scientific consensus surrounding ABA therapy after reviewing each of the studies in the record. Moreover, because she is an expert in the field, Dr. Grant's opinion is much more persuasive than that of Dr. Marks. From a review of the numerous articles and other material in the record, this court finds no basis for Dr. Marks's opinion that "ABA was not a well-proven or evidence-based standard of medical care, nor was it a standard of coverage within the industry." Indeed, just the opposite is the case.

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[5] An online article from the Kennedy Krieger Institute lists many of these entities including: National Institute of Mental Health, National Institute of Child Health and Human Development, The National Academies Press, American Association on Mental Retardation, American Psychological Association, Association for Science in the Treatment of Autism, the Surgeon General of the United States, New York State Department of Health, California State Department of Developmental Services, Florida State Department of Children and Families, and Maine Administrators of Services for Children with Disabilities. SR 968 (Louis P. Hagopian & Eric W. Boelter, *Applied Behavioral Analysis: Overview and Summary of Scientific Support*, *available at* http://www.kennedykrieger.org/kki_misc.jsp?pid=4761) (last accessed Jan. 5, 2010).

This court's view of the science is shared by multiple government agencies and professional organizations. For example, in 1999, the Department of Health and Human Services ("DHS") issued a report on the state of mental health and mental health treatment in the United States. One of its findings was that "[t]hirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." SR 975 (DHS, *Mental Health: A Report of the Surgeon General*, c. 3., p. 163 (1999), *available at* http://www.surgeongeneral.gov/library/ mentalhealth/pdfs/c3.pdf) (last accessed Jan. 5, 2010). The National Institute of Mental Health ("NIMH") has similarly concluded that "[a]mong the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment." SR 1106 (NIMH, *Autism Spectrum Disorders: Pervasive Developmental Disorders*, Doc. No. NIH 08-551 (2008), *available at* http://www.nimh.nih.gov/ health/publications/autism/nimhautismspectrum.pdf) (last accessed Jan. 5, 2010). Professional organizations concluding that ABA therapy is an appropriate treatment for autism include the American Association on Mental Retardation, American Psychological Association, and the Association for Science in the Treatment of Autism. SR 968.

That a given mental disorder has no absolute cure is not a basis for rejecting treatments which purport to alleviate or ameliorate its symptoms. Many treatments purport only to alleviate symptoms or increase the quality or length of life of those suffering from a chronic, incurable disease. Furthermore, the fact that ABA therapy is not effective for every autistic child is not a reasonable basis for concluding that it is experimental or investigational. It is possible for a

treatment to be both well-established and of limited efficacy in curing a neurological or mental disorder. Likewise, a scientific debate on the degree of improvement provided by a treatment or the instances in which it is the most effective does not show that the treatment is experimental or investigatory. The great majority of the studies in the record indicate that ABA therapy is not only supported by decades of research, but is one of the only autism treatments which has consistently shown measurable success in improving the lives of autistic children.[6] These studies, and the other sources cited above, demonstrate that ABA therapy has become one of the standard treatment options for autistic children throughout the nation. Notably, other than Dr. Marks's summary opinion, PacificSource has pointed to no authority in the record that has labeled ABA therapy an experimental or investigational treatment for autistic children or that declare it to be not a standard of care in Oregon or anywhere else.

Here PacificSource has submitted only one piece of evidence in support of its conclusion, namely the opinion of its own Chief Medical Officer. In light of the wealth of conflicting scientific research supporting ABA therapy, it was not reasonable for PacificSource to rely on

[6] *See*, *e.g.*, SR 894 (Francis, *supra*, at 495 (finding "[t]he literature shows that intensive behavioural therapy clearly benefits children with autism and yields a high degree of parental satisfaction; however, the original effectiveness claim was overstated and its cost-effectiveness, in terms of time, effort, and money, has not been adequately assessed")); SR 900 (Scott O. Lilienfeld, *Scientifically Unsupported and Supported Interventions for Childhood Psychopathology: A summary*, 115 Pediatrics 761, 762 (2005) ("The most efficacious psychosocial treatment for autism is applied behavior analysis . . . . In controlled within-subject studies, applied behavior analysis has demonstrated positive effects on autistic children's social and intellectual behaviors, although almost all of these children are left with serious deficits in adaptive functioning."); SR 913-15 (Howlin, *supra*, pp. 111-13 (finding that of all the treatments for autism, early behavioral intervention enjoys the most scientific support although there remain unanswered questions about its total efficacy and proper methodology)); SR 926 (Barbaresi, *supra*, at 1171 ("Decades worth of scientific research provide clear and convincing support for the technique referred to as [ABA].")); SR 932 (Filipek, *supra*, at 208 ("Behavioral, as opposed to pharmacologic, treatment is the hallmark of effective intervention for everyone with autism.")); SR 1323-34 (Dillenburger, *supra*, at 120-21 (noting that "[e]xtensive research over 30 years shows that early intensive behavioural intervention can lead to significant gains in cognitive, social, emotional, and motor functioning that can be generali[z]ed to other situations and maintained in the long term" and that "[a] review of over 500 studies shows that ABA consistently offers positive outcomes in terms of educating children with ASD and enhancing life skills")); SR 1471 (Remington, *supra*, at 418 (noting that an "increasing body of empirical research suggests that early, intensive, structured intervention, based on principles of applied behavioral analysis, is effective in remediating the intellectual, linguistic, and adaptive deficits associated with autism" and reporting that a two-year study conducted by the authors further confirmed this research)).

Dr. Marks's opinion alone. As a result, this court concludes that ABA therapy is not experimental or investigational in nature and that PacificSource lacked a reasonable basis reaching the opposite conclusion.

**c. Approved by the Centers for Medicare and Medicaid Services**

Second, PacificSource argues that ABA therapy is not approved for reimbursement by the Centers for Medicare and Medicaid Services ("CMS"). It relies upon a letter sent from the Oregon Department of Human Services ("ODHS") to McHenry's attorney explaining that it "does not currently recognize BCBA as a specific provider type," but "therapists, with a *specialty of BCBA*, can be enrolled with the Department as an approved County Mental Health Program (CMHP) provider" and may "bill any appropriate covered procedure codes, including autism." Shaw Decl. (docket #43), ¶ 2 & Ex. A, p. 1 (emphasis in original).[7] The letter plainly does not state that ABA is not reimbursable, but states only that BCBAs as a provider type are not recognized by the ODHS or CMS. Notably, the letter provides a specific method by which ABA therapy could be successfully billed. Thus, it does not provide a reasonable basis for concluding that ABA therapy is not approved for billing by the CMS.[8] Thus, PacificSource has failed to show that ABA therapy falls within the exclusion for experimental or investigative treatments.

**2. Educational Services**

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[7] Whether a treatment is approved for reimbursement by the CMS presumably is the basis for the ODHS approving it under the Oregon Health Plan. Neither party has addressed this issue.

[8] *Cf. Parents League for Effective Autism Servs. v. Jones-Kelley*, 565 F Supp2d 905, 915-16 (SD Ohio 2008) (granting TRO after finding that plaintiffs had a strong likelihood of success on their claim that ABA therapy was compensable under federal medicaid law), *aff'd in unpublished opinion*, No. 08-3931, 2009 WL 2251310 (6th Cir July 29, 2009).

PacificSource argues that ABA therapy, even if not experimental or investigatory, is excluded as "educational or correctional services or sheltered living provided by a school or halfway house." SR 1790.

As support, PacificSource points to Dr. Grant's statement that "ABA intervention for children on the autism spectrum have been shown over time to be highly effective in *teaching and generalizing skills* for these children in all areas of difficulty." SR 110 (emphasis added). Additionally, some of the articles cited by McHenry use language seemingly indicative of educational or social training. *See*, *e.g.*, SR 967 ("ABA-based approaches for *educating* children with autism and related disorders have been extensively researched and empirically supported.") (emphasis added); SR 1106 ("Among the many methods available for treatment and *education* of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment.") (emphasis added). Even advocates of ABA therapy describe it in terms that suggest it is educationally based. For example, Hoyt's website states that ABA therapy "[i]instruction focuses on *teaching* Core Learning Skills, Verbal Behavior, and social/play skills in natural and structured *learning* environments." SR 188 (emphasis added). Also, of the six categories of "treatment options" identified by the Autism Society for America ("ASA"), the ASA placed ABA therapy under the "Educational" category. SR 1089.

According to Dr. Marks, these sources agree with the literature he reviewed on ABA which "frequently referred to the persons receiving the therapy as 'learners'; the plans for working with the child as 'curricula'; referenced 'teacher/instructors,' and 'teacher/learner' ratios; and talked about teaching various skills in 'structured learning environments.'" Marks Decl., ¶ 6. He concludes that "applied behavioral analysis was more akin to remedial education

and 'generalization' skill techniques, and not clinical treatment *per se*." *Id*, ¶ 7. As a result, in his view, ABA therapy is properly classified along side special education classes or individualized education plans utilized to assist children with learning disabilities.

However, the full sentence of the exclusion reads as follows: "This plan does not cover educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter[.]" PacificSource reads the clause "provided by a school or halfway house" as modifying only "sheltered living." However, there is no comma separating "educational or correctional services" and "or sheltered living." As a result, the clause "provided by a school or halfway house" may be read as not only modifying "sheltered living," but also as modifying "educational or correctional services." Given this ambiguity, the language must be construed against PacificSource and in favor of McHenry. *McClure v. Life Ins. Co. of N. Am.*, 84 F3d 1129, 1134 (9th Cir 1996) ("ERISA insurance policies are governed by the rule that ambiguous language is construed against the insurer and in favor of the insured"). Construing the language most favorably to McHenry, even if ABA treatment were "educational," it is excluded only if it is "provided by a school or halfway house." J.M.'s services were not provided by a school or halfway house, but by an employee of a private company that provides rehabilitative services for autistic children. Thus, this exclusion does not apply.

**3. Academic and Social Skills Training**

Finally, PacificSource relies on the Plan's exclusion for "academic skills training . . . and social skills training." SR 1790. While acknowledging that ABA therapy may benefit an

autistic child's academic and social skills, McHenry counters that its primary focus is on modifying behaviors pertinent to every area of that child's life.

As discussed above, autistic children may exhibit many types of problem behavior detrimental to social or academic progression. A list assembled by one article includes: aerophagy/swallowing, aggression, bruxism/teethgrinding, coprophagy/feces eating, dawdling, destruction, depression, disruption/tantrum, drooling, elective mutism, elopement (run), feces smearing, fears, food refusal, food theft, genital stimulation, hallucinating, hyperactive behavior, hyperventilation, inappropriate vocalizations, insomnia, noncompliance, obesity, obsessive compulsive disorder, pica, public disrobing, rapid eating, rectal digging, rumination, seizure behavior, self-injurious behavior, stereotypy, tongue protrusion, and vomiting. SR 1235 (Robert H. Horner, *et al*, *Problem Behavior Interventions for Young Children with Autism: A Research Synthesis*, 32 J. Autism and Developmental Disorders 423, 431 (October 2002)).

It is reasonable to assume that a child exhibiting some of these behaviors would face serious obstacles to academic and social development. Autism's noted adverse impact on the ability of a child to form social connections or to express empathy or even awareness of another would have similar severe impacts in these areas. Indeed, the impairments caused by autism are acutely social in nature and the diagnostic criteria for autism require some "qualitative impairment in social interaction" in order to affirm a positive diagnosis. DSM-IV-TR at 70-71. Given the inherently social nature of the behavioral impairments caused by autism and the negative impacts of some of these behaviors on a child's academic development, it is no surprise that ABA therapy seeks to modify this behavior.

While ABA therapy may have beneficial effects on an autistic child's social and academic skills, its defining characteristic is application of techniques to modify behavior in every area of an autistic child's life. In this regard, a sports analogy is instructive. While participation in sports can benefit a students academic and social skills, no one would classify sports as academic or social skills training. Similarly, the incidental benefits in these areas resulting from ABA therapy, while real, do not dictate that it be classified as either as academic or social skills training. Rather, it is more properly classified as behavioral modification.

PacificSource's contrary interpretation would sweep many other covered benefits into this exception to which it clearly does not apply. Nearly all types of psychological treatment (counseling, psychotherapy, *etc*.) could be classified as academic or social skills training. These types of treatments, like ABA therapy, undoubtedly have benefits on a person's ability to succeed in education and help to teach proper skills and behaviors for social interactions. However, they would presumably not fall within those exclusions.

The focus of ABA therapy on discrete behaviors affecting all facets of living sets it apart. Researchers have found ABA to be effective in reducing problem behaviors, SR 1233 (Horner, *supra*, at 429), and in improving a child's ability to function in multiple areas including "intellectual, social, emotional, and adaptive functioning." SR 1252 (Svein Eikeseth, *et al.*, *Outcome for Children with Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7*, 31 Behavior Modification 264, 265 (2007). While aimed at improving social and academic functioning, it does this by specifically addressing behavioral deficits possessed by autistic children that interfere with every area of their life, not by educating kids on social norms or teaching study skills or other tools specific to academic success. To find for PacificSource on

this issue would be to improperly stress the benefits of ABA therapy in only two out of many areas of functioning.

According to the weight of the evidence, ABA therapy is not primarily academic or social skills training, but is behavioral training. Accordingly, it is not subject to the exclusions under the Plan for academic or social skills training.

### C. Eligible Provider

Although ABA therapy is medically necessary to treat J.M.'s autism, does not fall within any exclusion, and thus is a covered benefit under the 2007 Plan, McHenry is not entitled to reimbursement unless it is provided by an eligible provider. *See* SR 1772-74, 1778-79. The 2007 Plan defines eligible providers for mental health treatment as follows:

> **2. Provider Eligibility**. A provider is eligible for reimbursement if:
>
> a. The provider is approved by the Department of Human Services;
>
> b. The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities; or
>
> c. The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; and
>
> d. The provider is providing a covered benefit under this policy; and
>
> e. The provider meets the credentialing requirements of PacificSource.

SR 1778.

The 2007 Plan further defines "provider" as "a person who meets the credentialing requirements of PacificSource, is otherwise eligible to receive reimbursement under the policy,

and is . . . ; v. An individual behavioral health or medical professional authorized for reimbursement under Oregon law." *Id.*

The Member Benefits Handbook (or Summary Plan Description ("SPD")) contains a slightly different description of eligible providers of mental health services as persons or facilities:

> that meet the credentialing requirements of PacificSource, if credentialing is required, are otherwise eligible to receive reimbursement for coverage under the policy and are either a health care facility, a residential program or facility, a day or partial hospitalization program, an outpatient service, or an individual behavioral health or medical professional authorized for reimbursement under Oregon law.

SR 1837.

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Both the 2007 Plan[9] and SPD[10] provide a list of eligible providers. These lists are materially the same with BCBAs notably absent from both. That absence is immaterial because the SPD and Plan state only that "eligible providers *include*" and not "eligible providers *are limited to*" or similar exclusive language. *See Ariz. State Bd. For Charter Sch. v. U.S. Dep't of Educ.*, 464 F3d 1003, 1007 (9th Cir 2006) ("In both legal and common usage, the word 'including' is ordinarily defined as a term of illustration, signifying that what follows is an example of the preceding principle."), citing *Black's Law Dictionary*, 777-78 (8th ed. 2004) ("[t]he participle *including* typically indicates a partial list"). By way of contrast, the 2006 Plan included a restrictive clause, stating that "[o]nly the following providers . . . are eligible for reimbursement under this policy." SR 1722. PacificSource's decision to eliminate the restrictive clause in the 2006 Plan and replace it with a word commonly understood to proceed

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[9] The 2007 Plan provides that:

**Eligible providers include**:

a. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Alcoholism;
b. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Drug Addiction;
c. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Mental or Emotional Disturbance;
d. A medical or osteopathic physician licensed by the State Board of Medical Examiners;
e. A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
f. A nurse practitioner registered by the State Board of Nursing;
g. A clinical social worker (LCSW) licensed by the State Board of Clinical Social Workers;
h. A Licensed Professional Counselor (LPC) licensed by the State Board of Licensed Professional Counselors and Therapists;
i. A Licensed Marriage and Family Therapist (LMFT) licensed by the State Board of Licensed Professional Counselors and Therapists; and
j. A hospital or other healthcare facility licensed for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

SR 1779.

[10] Omitting the institutional providers, the SPD provides that:

"Eligible providers include: Licensed medical or osteopathic physicians (M.D. or D.O.), including psychiatrists, licensed psychologists (Ph.D.) and psychology associates, registered nurse practitioners (N.P.), licensed clinical social workers (L.C.S.W.), licensed professional counselors (L.P.C.), and licensed marriage and family therapists (L.M.F.T.).

SR 1837.

only a partial list is strong evidence that it did not intend the list of eligible providers in the 2007 Plan to be exhaustive.

Even so, PacificSource argues that Hoyt cannot be included with the other listed eligible provider types because she lacks the one attribute common to all others listed, namely, state licensing. While that may be true, the 2007 Plan nowhere explicitly requires state licensure as a precondition to provider eligibility. Thus, if Hoyt were to meet the explicit criteria set forth in the 2007 Plan, this nonexclusive list would not disqualify her even though she may not share one of the common features.

Turning to those explicit criteria, the court first recognizes not only significant overlap between the 2007 Plan's definitions of "provider" and "eligible provider" and the SPD's definition of "eligible provider," but also important distinctions. Combining the two terms used in the 2007 Plan to remove redundancies, Hoyt must: (1) be approved by ODHS; (2) meet PacificSource's credentialing requirements; (3) be authorized for reimbursement under Oregon law; and (4) provide a covered benefit or be "otherwise eligible" to receive reimbursement for coverage under the policy. The criteria in the SPD differ from these four elements in two important ways: first, the SPD only requires credentialing "if credentialing is required;" and second, there is no requirement that Hoyt be approved by ODHS. McHenry argues that the SPD controls.

To resolve a disagreement between plan documents, the court must adopt the language most favorable to the claimant. *See Bergt v. Retirement Plan for Pilots Employed by MarkAir, Inc.*, 293 F3d 1139, 1145 (9th Cir 2002). Accordingly, the court finds that the more favorable elements in the SPD control. In view of the evidence, as discussed below, it seems likely that

being approved by the ODHS is the method of being authorized for reimbursement under Oregon law. However, in the event of a distinction that neither party has pointed out, the court follows the terms of the SPD and removes approval by ODHS as one of the criteria.

Therefore, because Hoyt was providing a covered benefit under the Plan, as discussed above, to be eligible for reimbursement, McHenry must prove: (1) either that Hoyt met PacificSource's credentialing requirement or that PacificSource did not require her to be credentialed, and (2) that Hoyt was authorized for reimbursement under Oregon law.

**1. <u>Credentialing</u>**

It is undisputed that Hoyt has not been credentialed by PacificSource and does not meet its credentialing requirements. Instead, McHenry argues that no credentialing is required for Hoyt because she was a nonparticipating provider or a network not available provider.[11] Neither the 2007 Plan nor the SPD defines PacificSource's credentialing requirements or describes the process for becoming credentialed. These requirements are explained in two other documents, namely, the Physician and Provider Manual ("Provider Manual") (SR 735) and the Provider Network Management Credentialing Manual ("Credentialing Manual") (SR 870). As described by § 4.2 of the Provider Manual, the credentialing process "includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare providers." SR 755. The process is described in outline form in the Provider Manual and in greater detail in the Credentialing Manual.

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[11] A network not available provider is a non-participating provider located in an area where the member does not have reasonable access to a participating provider. SR 1771, 1823. The designation affects only the reimbursement rate; there appears to be no distinction between the two in terms of credentialing requirements.

Significantly, the Provider Manual states that if, after the credentialing process is completed, "the Credentialing Committee does not approve the provider, the provider may be considered a 'nonparticipating provider' and claims may be processed at the nonparticipating benefit level." SR 756. Based on this language, McHenry argues that only those providers who wish to be participating providers must pass the certification process. For those who cannot, the Provider Manual expressly provides for the option of reimbursing them at the non-participating provider rate.

Nothing in the Credentialing Manual contradicts the Provider Manual. Indeed, the general statement of policy on the first page of the Credentialing Manual reads: "PacificSource makes every effort to contract with qualified participating practitioners by using appropriate credentialing standards." SR 870. This language confirms McHenry's argument that credentialing is related to issues of contracting with approved providers. The remainder of the Credentialing Manual describes in detail the requirements necessary to become and remain a participating provider through the credentialing process. It also requires that "[a]ll participating practitioners will be recredentialed at a minimum of every three years (36 months)." SR 876. The Credentialing Manual provides no similar recredentialing requirements for nonparticipating providers.

PacificSource argues against McHenry's interpretation by pointing to Section 4.2.4 of the Provider Manual which provides a limited exception from credentialing for "providers who practice exclusively within the inpatient setting and who provide care for the health plans' members only as a result of members being directed to the hospital or other inpatient setting."

SR 757. According to PacificSource, this is the only class of providers who need not be credentialed.

The record reveals little else to resolve this issue. The 2007 Plan defines a nonparticipating provider as "a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource." SR 1752. This merely returns the reader to the definition of "provider" in the 2007 Plan requiring the person to be "credentialed." On the other hand, the SPD indicates that credentialing may not always be required and the Provider Manual states that a non-credentialed person may be reimbursed at the nonparticipating provider rate. While the Provider Manual contains only one explicit exception to the credentialing requirement, it also explicitly contemplates reimbursing a person for services provided by a practitioner who fails to meet PacificSource's credentialing requirements.

Given these conflicting provisions and the lack of a clear indication that all providers must be credentialed, the 2007 Plan is, at best, ambiguous on this issue. Given this ambiguity, the court must adopt the interpretation most favorable to McHenry. *McClure*, 84 F3d at 1134. Consequently, the court finds that Hoyt need not be credentialed with PacificSource to be considered an eligible provider.

### 2. <u>Authorized for Reimbursement Under Oregon Law</u>

Both the Plan and the SPD require an eligible provider to be authorized for reimbursement under Oregon law. The parties agree that ORS 743A.168(5) provides the applicable standards:

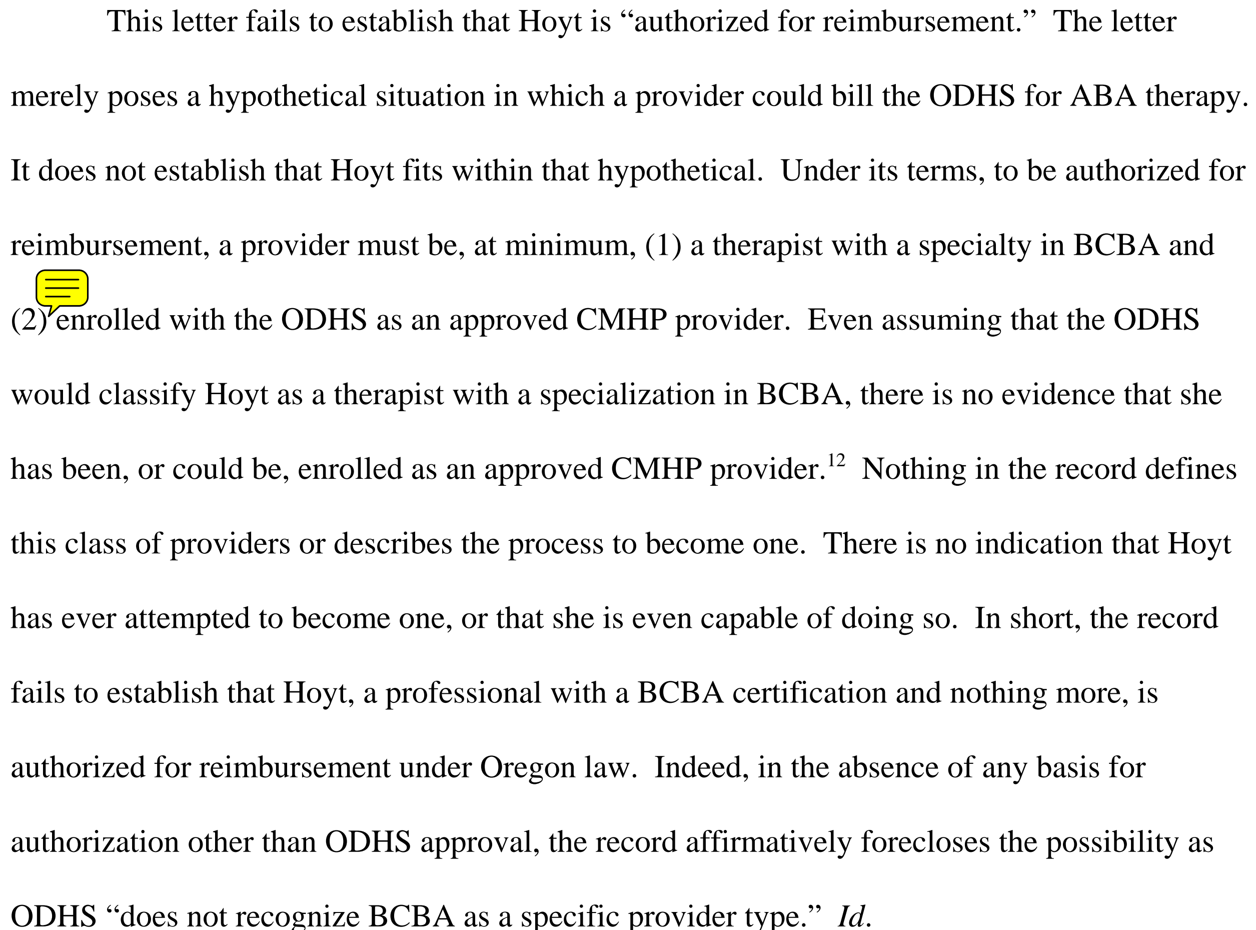
> (5) A provider is eligible for reimbursement under this section if:
> (a) The provider is approved by the Department of Human Services;
> (b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on

> Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
> (c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or
> (d) The provider is providing a covered benefit under the policy.

The four separate requirements are phrased in the disjunctive, meaning McHenry need satisfy only one to be "eligible for reimbursement." The final requirement renders a provider eligible for reimbursement simply by "providing a covered benefit under the policy." McHenry argues that because Hoyt was providing such a benefit (ABA therapy), she is eligible for reimbursement under Oregon law and thus satisfies the final requirement to be an eligible provider under the 2007 Plan.

But in order to be eligible for reimbursement, ORS 743A.168(5), like the 2007 Plan, requires that the person first be a "provider." In turn, a "provider" must have "met the credentialing requirements of a group health insurer," be "otherwise eligible to receive reimbursement for coverage under the policy" and be "[a]n individual behavioral health or medical professional authorized for reimbursement under Oregon law." ORS 743A.168(1)(e) These elements are identical to the 2007 Plan's definition of provider. The final element is the critical one here, namely that Hoyt has been, or could be, authorized for reimbursement.

Here McHenry's evidence consists only of the ODHS letter responding to her attorney's inquiry as to whether "[BCBAs] who treat children with [ASDs] are approved as providers by the Department of Human Services." Shaw Decl., ¶ 2, & Ex. A, p. 1. ODHS responded that the department "does not currently recognize BCBA as a specific provider type" but that "therapists, with a *specialty of BCBA*, can be enrolled with the Department as an approved County Mental Health Program (CMHP) provider." *Id* (emphasis in original). Once enrolled as a CMHP



provider, the therapist would be "able to bill any appropriate covered procedure codes, including autism, which is a covered diagnosis for the Oregon Health Plan[.]" *Id.*

This letter fails to establish that Hoyt is "authorized for reimbursement." The letter merely poses a hypothetical situation in which a provider could bill the ODHS for ABA therapy. It does not establish that Hoyt fits within that hypothetical. Under its terms, to be authorized for reimbursement, a provider must be, at minimum, (1) a therapist with a specialty in BCBA and (2) enrolled with the ODHS as an approved CMHP provider. Even assuming that the ODHS would classify Hoyt as a therapist with a specialization in BCBA, there is no evidence that she has been, or could be, enrolled as an approved CMHP provider.[12] Nothing in the record defines this class of providers or describes the process to become one. There is no indication that Hoyt has ever attempted to become one, or that she is even capable of doing so. In short, the record fails to establish that Hoyt, a professional with a BCBA certification and nothing more, is authorized for reimbursement under Oregon law. Indeed, in the absence of any basis for authorization other than ODHS approval, the record affirmatively forecloses the possibility as ODHS "does not recognize BCBA as a specific provider type." *Id.*

Because nothing in the record demonstrates that Hoyt is authorized for reimbursement for Oregon law, McHenry has failed to prove that Hoyt satisfies the definition of eligible provider under the 2007 Plan.

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[12] ORS 430.610-695 provides for the creation and oversight of CMHPs, and OAR 309-14-0020 provides specific requirements for the establishment and management of CMHPs within communities. In particular, organizations seeking to be contractually affiliated with the local mental health authority for the purpose of enrolling with the CMHP must apply to the CMHP for a certificate of approval. OAR 309-12-0160(2). There is no evidence in the stipulated record that either Hoyt or her employer, Building Bridges, contracted with the relevant CMHP to provide services for autistic children or received the requisite certificate of approval. The stipulated record also fails to reveal that Hoyt or Building Bridges applied for a certificate of approval as a qualifying "non-inpatient provider" under OAR 309-12-0160(3) for services provided in accordance with ORS 743A.168 or sought a variance from the administrative requirements pursuant to OAR 309-39-0580.

**D. Alternate Bases for Recovery**

**1. Limited Coverage for Ineligible Mental Health Providers**

McHenry offers two additional arguments for finding in her favor. The first relies upon the PacificSource internal policy titled "Administrative Procedure: Request for Ineligible Mental Health Providers." SR 725. This internal policy permits PacificSource to extend coverage for six visits to an otherwise ineligible provider where there exists "[l]icense equivalency," "[n]etwork accessibility" issues, or other special circumstances. *Id.* The six visits are intended to provide for "transitional care to an eligible provider[,]" but "[i]f compelling reasons and special circumstances are demonstrated, the Medical Director may approve additional visits." *Id.* Any benefits approved for an ineligible provider "are subject to non-participating provider benefit rates for approved services." *Id.*

McHenry argues that in light of the overwhelming evidence in the record demonstrating the necessity and efficacy of ABA therapy in this case and the utter absence of any other participating providers available in Clackamas County to provide ABA therapy (*see* SR 253-55, 1158), this policy should provide benefits even if Hoyt is not an eligible provider.

Even if she is correct, McHenry has not demonstrated the basis on which this court could enforce this policy. The policy appears to be a wholly discretionary internal procedure for handling claims which, in PacificSource's judgment, merit limited special consideration despite the lack of coverage under the terms of the 2007 Plan. It does not appear in the 2007 Plan or the SPD and is not otherwise incorporated into the Plan. In an action pursuant to 29 USC § 1132(a)(1), the plaintiff is only entitled to pursue or clarify benefits or rights due him "under

the terms of the plan." There is no basis for this court to expand those terms to include discretionary internal policies adopted by PacificSource.

**2. Illusory Contract**

Finally, McHenry argues that if J.M. is not entitled to ABA therapy under the 2007 Plan, then its purported coverage for autism is illusory. In construing a contract, "an interpretation which gives a reasonable, lawful, and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect." RESTATEMENT (SECOND) OF CONTRACTS § 203(a) (1981), quoted in *U.S. v. Franco-Lopez*, 312 F3d 984, 991 (9th Cir 2002). Thus, "the provisions of an ERISA plan should be construed so as to render none nugatory and to avoid illusory promises." *Carr v. First Nationwide Bank.*, 816 F Supp 1476, 1493 (ND Cal 1993) (citations omitted).

According to McHenry, ABA therapy is the "gold standard" of autism treatment, such that to exclude ABA therapy is to not treat autism. Therefore, she argues, if the Plan does not cover ABA therapy, then its autism coverage is purely illusory. It is equally illusory, then, to find that the 2007 Plan covers ABA therapy, but to construe its provider eligibility requirements to eliminate the only providers of ABA therapy.

In support of her argument, McHenry cites *K.F. ex rel. Fry v. Regence Blueshield*, No. C08-0890RSL, 2008 WL 4330901, at *4 (WD Wash Sept 19, 2008), where the court confronted a similar situation. In *Fry*, an ERISA-governed medical benefits plan provided home health care for medically necessary inpatient care. The plaintiff sought payment for hourly nursing services to provide that care, However, the plan expressly excluded payment for hourly nursing services. The court concluded that interpreting the plan to exclude in-home nursing would render its

promise of substituted services illusory in most circumstances because one of the primary reasons for inpatient care is round-the-clock nursing services. More importantly, the court found that the exclusion for hourly nursing services did not clearly apply to the substituted service provision. Under the doctrine of reasonable expectations,

> [a]n insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses conspicuous, plain, and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured.

*Id* at * 4, quoting *Saltarelli v. Bob Baker Group Med. Trust*, 35 F3d 382, 386 (9th Cir 1994).

By violating this doctrine, the court held that the exclusion did not apply.

Unlike the exclusion at issue in *Fry*, the eligible provider term in the 2007 Plan is a clear condition of coverage on which McHenry bears the burden of proof. To be an eligible provider, McHenry must prove that Hoyt was authorized for reimbursement under Oregon law. As discussed above, the evidence submitted by McHenry fails to meet that burden of proof. Therefore, the reasonable expectations doctrine is inapplicable to bar the exclusion that eliminates coverage here.

Moreover, there is insufficient evidence in the record to conclude that eliminating coverage for BCBAs would eliminate all coverage of ABA therapy under the 2007 Plan. The ODHS letter explicitly posits a scenario in which a practitioner providing ABA therapy would be authorized for reimbursement under Oregon law. Unfortunately, neither the letter nor anything else in the record establishes whether such a practitioner exists. In 2007, McHenry's husband contacted all of the participating mental health care providers in Clackamas County and found that none of them provides ABA therapy. SR 253-55, 1158. However, this evidence does not

establish that no ABA therapy practitioners are available who would meet the eligibility requirements of the 2007 Plan.

To the extent that other providers of ABA therapy are available to McHenry, or that Hoyt could become authorized for reimbursement herself by following the procedure outlined in the ODHS letter but has failed to do so, the lack of coverage is due to McHenry choosing a provider who is not covered by the Plan. That Hoyt is not authorized for reimbursement under Oregon law is solely a product of Oregon law, not an illusory contract of insurance. In that case, McHenry's remedy is with the Oregon State Legislature or the ODHS.

If the record established that no other possible providers of ABA therapy can be found within a reasonable geographic area, then the potential of illusory coverage would be much stronger. However, the record does not affirmatively establish that fact. Absent such evidence, the court is reticent to override the eligible provider provisions in the 2007 Plan as creating illusory coverage for autism. The specific provisions at issue are adopted wholesale out of Oregon's insurance code and, thus, reflect not only the bargain struck between McHenry and PacificSource, but also Oregon's public policy.

The requirement that Hoyt be authorized for reimbursement under Oregon law is not an unreasonable condition in the 2007 Plan. The purpose of the requirement appears to be to ensure that providers are subject to a state-sanctioned governing body which is able to set standards and exercise control over its members. Lacking such oversight of providers of ABA therapy, PacificSource would have no way to assure that the services being provided to its members are legitimate or uniform.

The court recognizes the hardship that its ruling may impose on McHenry and her family. However, ERISA only authorizes this court to grant benefits as provided for in the plan. The services provided by Hoyt are not covered under the 2007 Plan. Therefore, the court must deny McHenry's motion and grant PacificSource's cross-motion.

## FINDINGS OF FACT

1. ABA therapy is medically necessary to treat J.M.'s autism.

2. PacificSource has failed to establish that ABA therapy is an investigational or experimental treatment as those terms are defined by the 2007 Plan.

3. PacificSource has failed to establish that ABA therapy is educational as that term is defined by the 2007 Plan.

4. PacificSource has failed to establish that ABA therapy is academic or social skills training as those terms are defined by the 2007 Plan.

5. McHenry has failed to establish that Hoyt is authorized to receive reimbursement under Oregon law.

## CONCLUSIONS OF LAW

1. ABA therapy does not fall within any exclusion under the 2007 Plan and is therefore a covered benefit.

2. Hoyt is not an eligible provider under the 2007 Plan.

3. Under the terms of the 2007 Plan, McHenry is not entitled to reimbursement for the services provided by Hoyt.

## ORDER

McHenry's Motion for Summary Judgment (construed as a motion for judgment on the record) (docket #41) is DENIED and defendants' Cross-motion for Summary Judgment (construed as a cross-motion for judgment on the record) (docket #47) is GRANTED.

DATED this 5th day of January, 2010.

s/ Janice M. Stewart________________
Janice M. Stewart
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

LISA A. MCHENRY,

Plaintiff,

v.

PACIFICSOURCE HEALTH PLANS and THE METRO AREA COLLECTION SERVICE, INC. GROUP HEALTH/DENTAL PLAN,

Defendants.

CV-08-562-ST

OPINION AND ORDER

STEWART, Magistrate Judge:

## INTRODUCTION

The parties previously filed motions for summary judgment which this court construed as motions for judgment on the record pursuant to FRCP 52. On January 5, 2010, the court granted defendants' motion, denied plaintiff's motion, and entered judgment against plaintiff and in favor of defendants (dockets #59 and #60). On February 2, 2010, plaintiff, Lisa A. McHenry

("McHenry"), filed a Motion for Reconsideration pursuant to FRCP 59(a) (docket #64). For the reasons set forth below, McHenry's motion is granted. Upon reconsideration, this court finds that PacificSource breached its fiduciary duty to McHenry, but that further briefing is required to determine the consequences flowing from that breach.

**BACKGROUND**

McHenry is a participant in the Metro Area Collection Service, Inc. Group Health/Dental Plan which is insured by defendant, PacificSource Health Plans ("PacificSource"). McHenry's minor son, J.M., was diagnosed with autism in May 2006, at the age of one year and nine months. On or about November 20, 2006, J.M.'s pediatrician submitted to PacificSource a request for coverage for Applied Behavioral Analysis ("ABA") therapy. In January 2007, J.M. began receiving ABA therapy from Emily Hoyt ("Hoyt"), a Board Certified Behavior Analyst ("BCBA"). That ABA therapy has been effective in treating J.M.'s autism but at a substantial cost.

Hoyt submitted invoices to PacificSource for payment of services provided to J.M. from January through April 2007. SR 16-18.[1] In June 2007, PacificSource, as claims administrator, denied payment of these billings for the first time, explaining that the "[p]rovider is not eligible on this plan." SR 16. For the next several months, McHenry submitted numerous appeals and supporting documentation and each time was denied coverage. *See* SR 54, 93, 351. After exhausting her remedies with PacificSource, McHenry brought this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 USC §§ 1001-1461, to compel coverage.

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[1] "SR" refers to the stipulated record filed by the parties on May 22, 2009 (docket #46).

In support of their motions for summary judgment, the parties submitted a lengthy stipulated record documenting the exhaustive correspondence related to McHenry's appeals. In ruling on the summary judgment motions, the court found that in order to be eligible for reimbursement for J.M.'s treatment, ABA therapy must be medically necessary, a covered benefit under the 2007 Plan, and provided by an eligible provider. This court concluded that the ABA therapy is medically necessary to treat J.M.'s autism and that ABA therapy is a covered benefit not excluded as "experimental or investigational procedures," "academic skills training" or "social skills training" as those terms are defined by the 2007 Plan. However, the court found that McHenry is not entitled to reimbursement for the ABA therapy because she failed to establish that Hoyt is an eligible provider under the 2007 Plan. To be an eligible provider, Hoyt must be authorized to receive reimbursement under Oregon law.

With her request for reconsideration, McHenry has presented evidence that Hoyt is now authorized to receive reimbursement under Oregon law, thereby making her an eligible provider. McHenry claims that but for PacificSource's breach of its fiduciary duty, Hoyt would have been enrolled as a provider through the Oregon Department of Human Services ("ODHS") in mid-2007 and would have been qualified as an eligible provider under the 2007 Plan. In order to prevent a manifest injustice, McHenry urges the court to find that Hoyt is an eligible provider under the 2007 Plan, apply that eligibility retroactively, and amend the judgment accordingly.

**STANDARD**

As a threshold issue, the Federal Rules of Civil Procedure do not recognize a motion for reconsideration. "A district court may reconsider its grant of summary judgment under either Federal Rule of Civil Procedure 59(e) (motion to alter or amend a judgment) or Rule 60(b)

(relief from judgment)," depending on when it is filed. *See Sch. Dist. N. 1J, Multnomah County v. ACands, Inc.*, 5 F3d 1255, 1263 (9th Cir 1993). If filed within 28 days after entry of judgment, it is treated as a motion to alter or amend the judgment under FRCP 59(e). If filed more than 28 days, but less than one year after entry of judgment, it is considered a motion seeking relief from the judgment under FRCP 60(b).

McHenry brings her motion for reconsideration pursuant to FRCP 59(a), which allows the court, after a nonjury trial, to grant a new trial on all or some of the issues. However, no court trial was held in this case. Instead, the court construed the parties' motions for summary judgment as motions for judgment on the record pursuant to FRCP 52 and made findings of fact and conclusions of law based upon the record. Because McHenry filed her motion on February 2, 2010, exactly 28 days after entry of judgment on January 5, 2010, the court will construe her motion for reconsideration as an FRCP 59(e) motion to alter or amend judgment.

A motion brought under FRCP 59(e) "should not be granted, absent highly unusual circumstances," unless the district court: (1) is presented with newly discovered evidence; (2) committed clear error or the initial decision was manifestly unjust; or (3) if there is an intervening change in the controlling law. *389 Orange Street Partners v. Arnold*, 179 F3d 656, 665 (9th Cir 1999), citing *Sch. Dist. N. 1J*, 5 F3d at 1263. "A Rule 59(e) motion may not be used to raise arguments or present evidence for the first time when they could reasonably have been raised earlier in the litigation." *Carroll v. Nakatani*, 342 F3d 934, 945 (9th Cir 2003). Accordingly, "[a] district court has discretion to decline to consider an issue raised for the first time in a motion for reconsideration." *Novato Fire Prot. Dist. v. United States*, 181 F3d 1035, 1142 n6 (9th Cir 1999). "Whether or not to grant reconsideration is committed to the sound

discretion of the court." *Navajo Nation v. Confederated Tribes and Bands of the Yakima Indian Nation*, 331 F3d 1041, 1046 (9th Cir 2003), citing *Kona Ent., Inc. v. Estate of Bishop*, 229 F3d 877, 890 (9th Cir 2000).

**DISCUSSION**

In the short time since the entry of judgment, McHenry has taken extraordinary steps to enroll Hoyt as an eligible provider through ODHS. McHenry Aff. (docket #65), ¶¶ 1-9. She contends that because PacificSource violated its fiduciary duty to clearly inform her of the basis for denying her claim and of the steps necessary to perfect the claim, Hoyt was not enrolled as an eligible provider in 2007. Since Hoyt is now an eligible provider, McHenry urges this court to apply that eligibility retroactively.

Defendants respond that McHenry fails to present any newly discovered evidence within the context of FRCP 59(e) and impermissibly seeks to relitigate a matter already decided by the court. In the alternative, they assert that no breach of fiduciary duty occurred because PacificSource complied with all the regulatory notice requirements.

As a preliminary matter, McHenry has established a proper ground under which this court should reconsider its previous decision, namely to prevent a manifest injustice. McHenry's argument is precisely the type of "highly unusual circumstances" which may support reconsideration. Thus, the court will reconsider whether PacificSource breached a fiduciary duty, and if so, whether that breach constituted a manifest injustice.

**I. PacificSource's Fiduciary Duty**

PacificSource, as an ERISA insurer, is held to a fiduciary standard of care. *Firestone v. Bruch*, 489 US 101, 113 (1989). This duty requires claim administrators to give the insured

"specific reasons" for any denial and afford an opportunity for a "full and fair review" of the denial decision. 29 USC § 1133. The regulations further require that the claim denial must contain:

> (i) The specific reasons for the adverse determination;
> (ii) Reference to the specific plan provisions on which the determination is based;
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
> (iv) A description of the plan's review procedures . . .

29 CFR § 2560.503-1(g)(1).

The Ninth Circuit has explained that:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial; if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.

*Booton v. Lockheed Medical Benefit Plan*, 110 F3d 1461, 1463 (9th Cir 1991).

The provisions in 29 CFR § 2560.503-1(g)(1) are "designed to afford the beneficiary an explanation of the denial of benefits that is adequate to ensure meaningful review of the denial," and "enable the claimant to prepare adequately for any further administrative review, as well as appeal to the federal courts." *Vizcano v. Microsoft Corp.*, 120 F3d 1006, 1016 (9th Cir 1997), quoting *Halpin v. W.W. Grainger, Inc.*, 962 F2d 685, 689 (7th Cir 1992) (internal quotation marks omitted). It is the responsibility of the claims administrator to have a "meaningful dialogue" with plan participants to let them know specifically what information is needed to perfect their claim "in a manner calculated to be understood by the claimant." *Saffon v. Wells*

*Fargo & Co. Long Term Disability Plan*, 522 F3d 863, 870 (9th Cir 2008), citing *Booton*, 110 F3d at 1463.

**A. Denial Correspondence**

Between June and November 2007, PacificSource denied payment of J.M.'s ABA therapy several times.

**1. Initial Denial**

On June 10, 2007, PacificSource denied payment for services submitted by Hoyt, explaining only that the "[p]rovider is not eligible on this plan. See Covered Expenses section in your Member Benefits Handbook." SR 16. In response, McHenry submitted an Internal Grievance for the denial specifically asking "what would make a therapist eligible to provide [ABA therapy] on our plan [?]" and whether PacificSource "offer[ed] a plan that include[d] ABA therapy?" SR 20.

**2. Grievance Committee Denial**

PacificSource submitted McHenry's grievance to its Medical Grievance Review Committee ("Grievance Committee"). SR 50-53. By letter dated August 2, 2007, the Grievance Committee upheld PacificSource's denial of McHenry's claim for three reasons: (1) the Plan "specifically exclude[d] coverage for experimental or investigational procedures, services and treatments;" (2) "the plan exclude[d] academic or social skills training;" and (3) BCBAs, "while professionally educated, are not medically trained clinicians and are not eligible providers for PacificSource." SR 54. It then explained:

> This determination is based on the above exclusions and a lack of sufficient evidence-based peer-reviewed literature and other supporting data to establish this as a standard of care of coverage. The committee determined that Applied Behavior Analysis meets the plan definition of an

> experimental or investigational procedure. Pertinent plan language is enclosed for your review.

*Id*.

Enclosed with this denial letter was information related to the experimental/ investigational treatment exclusion and McHenry's appeal rights. SR. 57.

**3. Policy Committee Denial**

McHenry appealed this decision on August 6, 2007, to PacificSource's Policy and Procedures Review Committee, disagreeing with the conclusion that ABA therapy was experimental or investigational in nature and providing evidence that it was accepted as a scientifically based treatment for children with autism. SR 70-77. By letter dated August 28, 2007, the Policy Committee explained that "[a]fter reviewing all of the available information in this case, [it] determined that the services provided by ABA therapy are educationally based social/interactive skill training services" which were "specifically exclude[d]" by the Plan. SR 93. If McHenry believed any covered services were provided "in adjunct to ABA therapy," she could submit those services for a payment decision, but "as indicated in previous correspondence, *eligible services would need to be provided by an eligible medical or mental health provider* . . . ." *Id* (emphasis added). Included with the letter was information regarding appeal rights, but no further information about the cited exclusion or provider eligibility requirements. *Id*.

**4. Final Denial**

On September 24, 2007, McHenry submitted her written appeal, disputing the conclusion that ABA therapy was primarily educational or social skills training, submitting research and letters in support of her claim that ABA therapy resulted in improvement in numerous

therapeutic goals that are essential activities of everyday life. SR 108-112. After McHenry appeared and presented testimony at a hearing before the Membership Rights Panel ("MRP") on November 7, 2007 (SR 224-347), PacificSource sent its final denial letter on November 21, 2007, informing McHenry of the MRP's conclusion that ABA therapy was "behavioral-educational social skill training" specifically excluded by the Plan. SR 351. This final denial letter did not include provider eligibility as grounds for the denial.

**B. Analysis**

All of the denial letters referenced the relevant plan provisions upon which the denials were based and provided information regarding the plan's review procedures. While the denials gave varying reasons for the adverse benefit determination, they set forth specific reasons for the determination. However, none of the denials included a description of any additional material or information necessary that might be required for McHenry to perfect her claim as required by subsection (iii) of 29 CFR § 2560.503-1(g)(1).

The only mention of any mechanism for submitting additional information was included in the Policy Committee's August 28, 2007 denial letter, which instructed McHenry that she could submit payment for covered services being provided "in adjunct to ABA therapy," but that those services would "need to be provided by an eligible medical or mental health provider." SR 93. Such a general statement does not satisfy PacificSource's duty to provide McHenry with "a description of any additional material or information necessary for [her] to perfect the claim and an explanation of why such information is necessary." 29 CFR § 2560.503-1(g)(1)(iii); *see Tinker v. Verstata, Inc.*, 566 F Supp2d 1158, 1164 (ED Cal 2008) (finding that a plan administrator committed "clear and flagrant failure" by merely stating in the termination letter

that if claimant had "additional medical information" or wished for reconsideration of the decision, she should submit a formal request within 60 days).

Moreover, McHenry specifically asked what would make a provider eligible, but PacificSource failed to respond with that information. Recently, another court found that it is the responsibility of the claims administrator to inform the claimant what type of information it needed, especially if the claimant requests guidance. *Lavino v. Metro. Life Ins. Co.*, 2010 WL 234817 *9-10 (CD Cal January 13, 2010) (finding that administrator cannot deny a claim based upon the claimant's "failure to produce objective evidence," when the claim administrator never responded to claimant's repeated requests for guidance on what type of "objective evidence" was sought by the administrator), citing *Saffon*, 552 F3d at 870-73.

Not only did the denials fail to provide any description of what was necessary to perfect the claim, they also failed to give McHenry the information she needed to adequately prepare for appeal. While PacificSource complied with the requirement to give specific reasons for the adverse determination, it did not give consistent reasons which misled McHenry regarding the grounds for denial. Had PacificSource satisfied its duty to inform McHenry of the information necessary to perfect her claim, the inconsistent reasons would have been inconsequential. Instead, this failure lead McHenry to believe that the basis for denial was not Hoyt being an ineligible provider as stated in the June 10, 2007 initial denial, but that ABA therapy was not a covered benefit due to various plan exclusions. Of course, the two bases are related since no provider would be eligible to provide ABA therapy unless it was a covered benefit. In other words, as long as the plan excluded ABA therapy, whether Hoyt was an eligible provider was

irrelevant. Not until this court ruled that ABA therapy is a covered benefit has the issue of an eligible provider become paramount.

At all times, McHenry tirelessly pursued the avenues which PacificSource communicated to her as the reasons for denying her claims. While the August 2, 2007 denial by the Grievance Committee cited three reasons for denying the claim, it only included the specific plan provision for the experimental/investigational procedure exclusion. Accordingly, McHenry focused her appeal on this exclusion. The Policy Committee denial dated August 28, 2007, cited the educationally based social/interactive skill training services exclusion as the primary basis for the denial. So McHenry changed her strategy, appealed, and submitted documentation and evidence related to this exclusion. At each level of appeal, McHenry relied upon the information provided by PacificSource as the grounds for denial in order to challenge the adverse benefit determination.

In response, PacificSource asserts that the regulatory provisions require only an adequately investigated and reasoned review which it provided. Specifically, PacificSource asserts that it "thoroughly investigated" Hoyt's eligibility by performing a licensure check and placing a telephone call to Hoyt asking for additional information about her license and credentials, as related in a September 24, 2007 letter sent to Oregon Insurance Division. SR 106; Defendants' Response (docket # 69), p. 8. While this letter is not addressed to McHenry, excerpts appear in the materials submitted with her appeal to the MRP at the November 7, 2007 hearing. *See* SR 226-27. This leads to the logical conclusion that she received it before then.

Whether McHenry actually received the letter is not dispositive because the letter relates only the results of PacificSource's investigation that Hoyt did not have the required licensure to

satisfy its credentialing requirements. It does not include any information describing those credentialing requirements or how to otherwise perfect an ineligible provider claim. The two paragraphs setting forth PacificSource's licensure check and telephone call made to Hoyt is evidence that PacificSource did investigate Hoyt's eligibility and communicated the result of that investigation to McHenry. However, given the 2007 Plan's complex provider eligibility requirements, discussed in detail in this court's January 5, 2010 Opinion and Order, the letter does not establish that PacificSource communicated to McHenry "in a manner calculated to be understood by [her]" the information needed to perfect her claim. *See Saffon*, 522 F3d at 870.

PacificSource also relies upon emails exchanged in late October 2007 regarding McHenry's inquires about obtaining a list of participating ABA therapy providers. SR 215-17. PacificSource appears to assert that because it ultimately provided McHenry with a list of participating psychologists, it satisfied its responsibility to engage in a meaningful dialogue with her. SR 217. Notably, McHenry requested a list of participating providers based upon treatment patterns. In producing the list of participating psychologists, PacificSource stated that it did not know whether any of the participating psychologists provided ABA therapy. SR 215-17. In fact, none of them did. *See* SR 253-55. In any event, PacificSource's communications with McHenry never answered her question regarding what makes a provider eligible under the plan or even included any general information relating to the plan's provider eligibility requirements.

In support of its contention that its communication with McHenry was adequate, PacificSource relies on a decision by this court holding that the claims administrator "was not required to provide an exhaustive list of every possible piece of . . . evidence that could conceivably strengthen [claimant's] application; rather, the regulations [require the claims

administrator] to advise [the claimant] of what information it needed to intelligently evaluate [the] claim." *Harris v. Standard Ins. Co.*, 2008 WL 917119 *10 (D Or March 26, 2008). This court found adequate a general statement relating to claimant that additional medical information could be submitted and would be helpful if it would support claimant's assertion that the condition was more severe than previously understood. *Id*. In contrast, PacificSource made *no* statement relating what additional information might be helpful to McHenry's claim or why.

The record is clear that despite McHenry's repeated requests for guidance, PacificSource never provided a description of any additional material or information necessary to perfect the provider eligibility claim. This complete failure to communicate regarding eligibility requirements is not the type of "meaningful dialogue" that the Ninth Circuit requires between claim administrators and beneficiaries. To allow PacificSource to financially benefit from that failure would be a manifest injustice. Had McHenry known at the time of her appeals in 2007 that PacificSource's eligible provider requirements required Hoyt to be authorized for reimbursement by being enrolled with ODHS, there is no doubt that she would have pursued enrollment of Hoyt, as she has done in the short time since becoming aware of this requirement.

This court previously found that Hoyt is not an eligible provider under the 2007 Plan. Simply because Hoyt now has become an eligible provider does not make that finding erroneous unless Hoyt is retroactively granted that status to some earlier date. However, it is not at all clear, and there is no way to know, if Hoyt actually could have been enrolled as a provider at any earlier date. Thus, this court has no factual basis to apply Hoyt's eligibility as a provider retroactively to 2007 as requested by McHenry. In addition, McHenry did not allege a separate claim for breach of fiduciary duty, but alleged only that she is entitled to payment of benefits for ABA therapy. In

her motion for summary judgment, she argued that defendants committed several ERISA violations, including committing notice violations in its denials, and that PacificSource violated its fiduciary duty by failing to conduct an external review. Based on those violations, she claimed that she was prejudiced during the appeal process, but did not request any particular relief as a result.

At this point, this court cannot determine what consequences legally flow from PacificSource's failure to inform McHenry of the information needed to perfect her provider eligibility claim and what equitable relief, if any, would be appropriate to remedy that failure. Therefore, this court requires further briefing from the parties before amending the judgment.

**ORDER**

Based on the above, McHenry's Motion for Reconsideration (docket #64) is construed as a motion to alter or amend judgment under FRCP 59(e). To address what relief, if any, should be awarded to McHenry as a result of the breach of fiduciary duty by PacificSource by failing to inform McHenry of the information needed to perfect her provider eligibility claim, the parties shall submit supplemental briefing according to the following schedule:

May 3, 2010: McHenry's Supplemental brief is due;

May 17, 2010: Defendants' Response is due;

June 1, 2010: McHenry's Reply is due.

DATED this 16th day of April, 2010.

s/ Janice M. Stewart__________________
Janice M. Stewart
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

LISA A. MCHENRY,

Plaintiff,

v.

PACIFICSOURCE HEALTH PLANS and THE METRO AREA COLLECTION SERVICE, INC. GROUP HEALTH/DENTAL PLAN,

Defendants.

CV-08-562-ST

OPINION AND ORDER

STEWART, Magistrate Judge:

## INTRODUCTION

Resolving the parties' prior motions for summary judgment (construed as motions for judgment on the records pursuant to FRCP 52), this court concluded that Applied Behavioral Analysis ("ABA") therapy was a covered benefit under the 2007 Plan, but that McHenry had

failed to establish that Emily Hoyt ("Hoyt"), a Board Certified Behavior Analyst ("BCBA"), who provided ABA therapy to McHenry's son, J.M., was an eligible provider (docket #59). Therefore, the court entered a judgment in favor of defendants (docket #60). As the prevailing parties, defendant filed a Bill of Costs (docket #61).

McHenry then filed a Motion for Reconsideration (construed as Motion to Alter or Amend Judgment) (docket #64) and presented evidence that Hoyt had become authorized to receive reimbursement under Oregon law, making her an eligible provider. In its April 16, 2010 Opinion and Order (docket #74), the court found that PacificSource violated the notice requirements of 29 CFR § 2560.503-1(g)(1)(iii) during the claims review process by failing to inform McHenry of the information needed to perfect her claim and concluded that it would be a manifest injustice to allow PacificSource to financially benefit from that failure. The court ordered the parties to address in supplemental briefing what equitable relief, if any, should be awarded to McHenry as a result of the breach of fiduciary duty by PacificSource.

Because McHenry did not allege a claim for breach of fiduciary duty in her initial Complaint, she has filed a Motion for Leave to File First Amended Complaint seeking declaratory and injunctive relief under 29 USC § 1132 (a)(3) (docket #76). Her proposed First Amended Complaint seeks a declaration that Hoyt is an eligible provider effective January 10, 2007, when she began to provide ABA therapy to J.M. Accordingly, McHenry also seeks an order requiring defendants to cover J.M.'s ABA therapy pursuant to the 2007 Plan for the period January 10, 2007, through March 31, 2010, in the amount of $50,939.00, and into the future for his continuing necessary ABA therapy. Defendants oppose the filing of the proposed First Amended Complaint as untimely and prejudicial and also have filed a Motion for Amendment of

Findings and Judgment under FRCP 52(b) (docket #94), contending that the court erred by concluding that PacificSource breached its fiduciary duty.

For the reasons set forth below, the court adheres to its prior ruling that PacificSource breached its fiduciary duty, but finds that McHenry cannot recover the various types of relief she requests as a remedy. Instead, based on reconsideration, McHenry is awarded benefits under the 2007 Plan for J.M.'s ABA therapy provided by Hoyt after she became an eligible provider on February 5, 2010. Accordingly, McHenry's Motion for Reconsideration is granted in part, but McHenry's Motion to File First Amended Complaint and defendants' Motion for Amendment are both denied.

## I. Defendants' Motion for Amendment of Findings and Judgment

Granting defendants' Motion for Amendment of Findings and Judgment would eliminate any claim for breach of fiduciary duty by PacificSource and, thus, would render McHenry's proposed amended complaint moot. Therefore, it is addressed first.

### A. Legal Standard

Pursuant to FRCP 52(b), a party may timely request the court to amend its findings and judgment to correct manifest errors of fact or law.[1] A Rule 52(b) post-judgment motion "permits counsel to ask the court to correct, on the non-jury record before it, any errors of law, mistakes of fact or oversights that require correction." *U.S. Gypsum Co. v. Schiavo Bros., Inc.*, 668 F2d 172, 180 (3rd Cir 1981), *cert. denied*, 456 US 961 (1982). Such motions "are primarily designed to correct findings of fact which are central to the decision and are not intended to serve as a

[1] The rule requires that the motion be filed "no later than 28 days after the entry of judgment." FRCP 52(b). The court entered its order on April 16, 2010. PacificSouce filed its motion to amend on May 24, 2010, which is 38 days later. Notwithstanding its untimeliness, the court will consider the motion.

vehicle for a rehearing." *United States v. Oregon*, 666 F Supp 1461, 1466 (D Or 1987). They may be "appropriate where, for example, the Court has patently misunderstood a party, or has made a decision outside the adversarial issues presented to the Court by the parties, or has made an error not of reasoning but of apprehension." *333 West Thomas Med. Bldg. Enters. v. Soetantyo*, 976 F Supp 1298, 1302 (D Ariz 1995), *aff'd*, 111 F3d 138 (9th Cir 1997).

In her Motion for Reconsideration, McHenry presented new evidence, outside the administrative record, that Hoyt had become eligible for reimbursement by enrolling as a "Behavior Consultant" with the Children's Intensive In-Home Services Behavior Program ("CIIS Program") in the Senior and People with Disabilities Division ("Disabilities Division") of the Oregon Department of Human Services ("ODHS"). Defendants did not respond with any argument based on Oregon law governing provider eligibility at that time, but now seeks to remedy that failure through this motion. Although defendants had a full and fair opportunity to present this argument in response to McHenry's Motion for Reconsideration, this court will consider their belated argument contesting Hoyt's eligibility in an abundance of caution to avoid legal error.

**B. Hoyt as Eligible Provider**

First, defendants contend that, contrary to this court's prior findings, Hoyt did not, could not, and still does not satisfy the eligible provider requirements.

The requirements for insurance reimbursement eligibility under Oregon law are found in ORS 743A.010 *et seq*. ORS 743A.168 prescribes the requirements for provider eligibility criteria under group health policies and defines "provider" as follows:

> (e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement

> for coverage under the policy and is:
> (A) A health care facility;
> (B) A residential program or facility;
> (C) A day or partial hospitalization program;
> (D) An outpatient service; **or**
> **(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.**

ORS 743A.168(1)(e) (emphasis added.)

A provider "is eligible for reimbursement" under Oregon law if:

> (a) **The provider is approved by the Department of Human Services;**
> (b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;
> (c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; **or**
> (d) The provider is providing a covered benefit under the policy.

ORS 743A.168(5) (emphasis added.)

The 2007 Plan adopts almost verbatim the statutory requirements for insurance reimbursement eligibility under ORS 743A.010 *et seq*. The 2007 Plan further defines a "provider" for mental health services as "a person who meets the credentialing requirements of PacificSource, is otherwise eligible to receive reimbursement under the policy, and is … [a]n individual behavioral health or medical professional authorized for reimbursement under Oregon law." Those policy provisions are essentially identical to the statutory requirements for insurance reimbursement eligibility under ORS 743A.168(1)(e) and (5). This court previously determined that due to conflicting provisions regarding the credentialing requirement, Hoyt need not be credentialed with PacificSource to be considered an eligible provider. *See* Opinion and Order (docket #59), pp. 31-33. Thus, the relevant inquiry is whether she is authorized for reimbursement under Oregon law.

Defendants argue that Hoyt lacks the credentials and certification needed to make her and her organization eligible for reimbursement as a provider "approved by" ODHS under ORS 743A.168(5)(a). In support, defendants cite the procedures and standards in OAR Chapter 309 that require organizations to obtain a "Certificate of Approval" from ODHS to be eligible for insurance reimbursement, with individual providers becoming eligible for insurance reimbursement through the approval certificates of their organizations.

The regulations governing the procedures for obtaining an ODHS "Certificate of Approval" for insurance reimbursement purposes are found at OAR 309-012-0130 to 0220. OAR 309-039-0500 to 0580 prescribe the eligibility standards for mental health providers. To obtain a "Certificate of Approval" for insurance reimbursement of mental health services, OAR 309-039-0540(3)(a) requires that a provider may use only "qualified supervisors and qualified mental health professionals [to] provide individual, group and family therapy." A close review of the regulations reveals that neither Hoyt nor her organization, Building Bridges, would satisfy the criteria necessary to obtain a "Certificate of Approval" because neither satisfy the regulations' standards for qualified supervisors and qualified mental health professionals authorized to provide therapy services. *See* OAR 309-039-0510(12), (13).

However, OAR Chapter 309 governs the Addictions and Mental Health Division of ODHS and controls coverage of organizations rather than individuals like Hoyt. Potter Aff. (docket # 108), ¶¶ 3-4. Defendants mistakenly assume that Hoyt must enroll under the Addiction and Mental Health Division to be eligible for reimbursement under the Plan. That assumption is not supported by the Plan which requires only that the mental health provider be approved by ODHS, without specifying by which division. While ODHS is subdivided into

separate divisions, including the Addiction and Mental Health Division and the Disabilities Division, the Plan makes no such distinction. It identifies as covered mental health services all services provided by any eligible provider to treat all conditions set forth in the DSM-IV, except certain excluded conditions. The issue is not how the services are classified by ODHS, but whether they are covered services under the Plan and whether Hoyt has enrolled as required in accordance with the Plan's requirements. The Plan does not require Hoyt's organization to have a Certificate of Approval from ODHS in order to become a covered provider. It only requires that an individual be authorized for reimbursement under Oregon law.[2]

Hoyt is enrolled as a Behavior Consultant pursuant to Division 300 of OAR Chapter 411 (OAR 411-300-0100 through 0220), which applies to the CIIS Program under the Disabilities Division. Baker Aff. (docket # 109), ¶¶ 3, 5. Division 300 of Chapter 411 distinguishes between a Provider and a Behavior Consultant by prescribing specific qualifications and duties for each. OAR 411-300-0150, 0170, & 0190. OAR 411-300-0110(4) defines a Behavior Consultant as "a contractor with specialized skills who develops a behavior support plan."

In approving Hoyt's application, the Disabilities Division determined that she met the requirements for a Behavior Consultant as prescribed in OAR 411-300-0170(2). The criteria Hoyt met as a BCBA were substantially similar to these requirements. To become a BCBA, Hoyt was required to complete 225 hours of graduate level instruction in several content areas, including ethical considerations, definition and characteristics and principles, behavioral

[2] The court referenced OAR Chapter 309 in its earlier Opinion and Order granting summary judgment (docket #59, p. 35, n. 12) when discussing Hoyt's original argument that she could be enrolled with ODHS as a provider through the County Mental Health Program ("CMHP") which requires that organizations have a Certificate of Approval. That reference does not change the fact that the Plan does not require that a provider be enrolled under a specific division or obtain a Certificate of Approval.

assessment, experimental evaluation of interventions, measurement of behavior, and behavior change procedures. SR 1161. She also had to accumulate field experience, including conducting assessment activities related to the need for behavioral interventions; designing, implementing and monitoring behavior analysis programs; and overseeing the implementation of behavior analysis programs by others. SR 1162. Thus, Hoyt's education, training and duties as a BCBA closely mirror the training, education and skills required of a Behavior Consultant under Oregon law. *Compare* OAR 411-300-0150(4) *with* SR 1161-62.

Hoyt's enrollment as a Behavior Consultant within the CIIS Program satisfies the purpose behind Oregon's statutory reimbursement requirements for non-licensed providers since she is subject to a state-sanctioned governing body which sets standards and exercises control over its members. As an ODHS-approved Behavior Consultant, Hoyt is subject to oversight by ODHS through a Services Coordinator. *See* OAR 411-300-0110(25) (the Services Coordinator ". . . provides assessment, case planning, service implementation, and evaluation of the effectiveness of the services"); OAR 411-300-0130(2)(d) (identifying the "number of hours of in-home daily care or behavior consultation authorized for the child"), and OAR 411-300-0130(3)(c) (sets the date for review by the services coordinator of the "Plan of Care"). In addition, as an ODHS-approved Behavior Consultant, Hoyt must submit the following to the Disabilities Division:

> (a) An evaluation of the child, the parent's concerns, the environment of the child, current communication strategies used by the child and used by others with the child, and any other disability of the child that would impact the appropriateness of strategies to be used with the child; and
> (b) Any behavior plan or instructions left with the parent or provider that describes the suggested strategies to be used with the child.

OAR 411-300-0190(6).

ODHS's decision approving Hoyt as a Behavior Consultant demonstrates that Hoyt meets all of the requirements set forth in OAR 411-300-0100 through 0220. As an enrolled Behavior Consultant with ODHS, by definition, Hoyt is "an individual behavioral health . . . professional authorized for reimbursement under Oregon law." ORS 743A.168 (1)(e)(E). She is authorized to receive payment for all behavioral consulting services that she performs for any ODHS patient or client, or will be reimbursed by ODHS for such services she provides, in accordance with OAR 411-300-0100 through 0220. Baker Aff., ¶ 5.

The statutory framework for Division 300 of OAR Chapter 411 regulates the CIIS Program, which is designed to provide support for families of children with developmental disabilities and intense behaviors. Accordingly, the eligibility of children to enroll in the CIIS Program, qualification of providers, and the type of services available are closely regulated by Division 300. As a Behavior Consultant, Hoyt is authorized to provide specific services within the CIIS Program and presumably also would be qualified to provide similar services to children outside of the CIIS Program.

The Plan does not provide any details as to how one might become authorized for reimbursement under Oregon law, what division one must enroll in, or whether one must be authorized to provide therapy or only to provide consultant services. Whether Hoyt may be reimbursed for services provided outside of the CIIS Program is not relevant to the present inquiry because the Plan does not require anything more than authorization for reimbursement under Oregon law. To the extent the Plan is ambiguous in this regard, the court must adopt the interpretation most favorable to McHenry. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F2d 534, 539-40 (9th Cir) (as amended), *cert. denied*, 498 US 1013 (1990), *reh'g denied*, 498 US 1074

(1991). Thus, Hoyt is provider under the terms of the Plan because she is approved by ODHS and, therefore, is "authorized for reimbursement under Oregon law," as the Plan requires.

**C. Compliance with Notice Requirements**

Second, defendants argue that, contrary to this court's findings, PacificSource substantially complied with the notice requirements prescribed by 29 CFR § 2560.503-1(g)(1)(iii) by, among other things: (1) explaining through numerous correspondence the reasons for the denial (provider not eligible); (2) investigating and obtaining the necessary information on McHenry's selected provider, Hoyt and her organization (Building Bridges), to accurately determine that the provider was not eligible under the Plan; and (3) identifying and consistently stating to McHenry that a provider must satisfy the statutory requirements listed under ORS 743A.168 and adopted by the Plan. PacificSource argues that it had no duty to describe any additional information or materials necessary for McHenry to perfect her claim.

PacificSource did provide McHenry with specific reasons for its adverse benefit determination. However, none of the denials complied with 29 CFR § 2560.503-1(g)(1)(iii) which specifically requires "a description of any additional materials or information necessary for [McHenry] to perfect the claim and an explanation of why such material or information is necessary." PacificSource contends that the court wrongly presumed that additional information or materials were necessary, based on its erroneous finding that Hoyt's enrollment as a Behavior Consultant with ODHS's CIIS Program was sufficient to satisfy Oregon's statutory insurance reimbursement requirements. If PacificSouce is correct, then it needed no additional information or materials to evaluate McHenry's claim, and its investigation correctly concluded that Hoyt did not and could not satisfy eligibility requirements.

However, as discussed above, Hoyt's enrollment with ODHS's CIIS program is sufficient to satisfy Oregon law and the Plan's requirements. At no time during the denial process did PacificSource provide any information regarding how a provider could become eligible under the Plan, despite McHenry's repeated requests for this information. Accordingly, this court stands by its earlier conclusion that PacificSource breached its notice obligation by failing to communicate with McHenry regarding provider eligibility requirements.

PacificSource also takes issue with this court's finding that it focused on different grounds for denial throughout the denial process. It maintains that its denials were consistently based on both the exclusion of ABA therapy as a covered benefit and the ineligibility of McHenry's provider. It also highlights that some correspondence refers to provider eligibility, that Hoyt did not and could not satisfy Oregon's statutory eligibility requirements, that its explanations for denying the claim were based on its erroneous interpretation of the 2007 Plan at the time, and that McHenry was represented by counsel who never sought guidance concerning the statutory eligibility requirements.

However, the fact remains that PacificSource shifted focus several times in its denial letters, and this caused McHenry to change the focus of each of her appeals. McHenry was aware that provider eligibility was a basis of the denial and repeatedly sought additional guidance regarding provider eligibility, but she was never provided clear information regarding what makes a provider eligible under the Plan. This is likely due to PacificSource's reluctance to focus upon provider eligibility as the primary basis for denying the claim and preference to instead focus on the various exclusions as a "more primary and more solid argument." SR 105.

PacificSource's letter addressed to Yani Horst, a consumer protection advocate, further

underscores this point. SR 212. In that letter, after discussing provider credentialing, PacificSource states that it "would only reimburse for services covered under the health plan regardless of an individual's credentials." *Id*. Because PacificSource did not consider ABA therapy a covered benefit, the provider's eligibility was an afterthought, as reflected by the denial notices. The court previously considered and rejected the argument that PacificSource engaged in a meaningful dialogue with McHenry regarding the basis for the denial of her claim and, after further review, adheres to the same conclusion.

Defendants also maintain that McHenry would not have acted sooner to make Hoyt eligible for reimbursement even if she had been informed of Oregon's statutory requirements for insurance reimbursement eligibility. McHenry did not vary in her argument why Hoyt was eligible for reimbursement, specifically because a provider is eligible for reimbursement under Oregon law and the terms of the 2007 Plan if the provider was providing a covered benefit. They contend that she changed her position only after the court found to the contrary and held that a provider is eligible for reimbursement only by satisfying the statutory requirements listed under ORS 743A.168 and the terms of the Plan.

The record on the whole does not support defendants' argument. At every stage of the denial process McHenry addressed and challenged the reasons provided for her claim denial. For instance, when it became clear that PacificSource was denying the claim upon its belief that ABA was not a covered benefit, McHenry focused her energy and efforts on challenging PacificSource's cited Plan exclusions. As the record shows, the complete failure to consistently and clearly communicate with McHenry resulted in McHenry's failure to diligently pursue enrollment earlier in the process. Had PacificSource fulfilled its duty, then the court would not

have had to provide her with the information she needed at such a late date.

### D. **Conclusion**

Defendants' Motion for Amendment of Findings and Judgment (docket #94) is denied because: (1) Hoyt's enrollment as a Behavior Consultant with ODHS's CIIS program satisfies the Plan's provider eligibility requirements; and (2) PacificSource did not satisfy the notice requirements prescribed by 29 CFR § 2560.503-1(g)(1)(iii) by failing to communicate regarding the Plan's provider eligibility requirements and providing the information necessary to perfect the claim.

## II. **McHenry's Motion to File Amended Complaint**

### A. **Legal Standard**

"When an issue not raised by the pleadings is tried by the parties' express or implied consent, it must be treated in all respects as if raised in the pleadings. A party may move — at any time, even after judgment — to amend the pleadings to conform them to the evidence and to raise an unpleaded issue." FRCP 15(b)(2). The purpose of the rule is "to allow an amendment of the pleadings to bring them in line with the actual issues upon which the case was tried." *Campbell v. Board of Trustees*, 817 F2d 499, 506 (9th Cir 1987) (citation omitted).

The rule and relevant case law reflect the liberal policy favoring amendments of pleadings at any time. *Consolidated Data Terminals v. Applied Digital Data Sys., Inc.*, 708 F2d 385, 396 (9th Cir 1983). Deciding whether to grant leave to amend, the Supreme Court has offered the following guidance:

> In the absence of any apparent or declared reason — such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of

> allowance of the amendment, futility of amendment, etc. — the leave sought should, as the rules require, be "freely given."

*Foman v. Davis*, 371 US 178, 182 (1962).

Of these factors, consideration of prejudice to the opposing party carries the greatest weight. *Eminence Capital, LLC v. Aspeon, Inc.*, 316 F3d 1048, 1052 (9th Cir 2003).

**B. Prejudice**

Defendants first oppose McHenry's motion as prejudicial because the issue of breach of fiduciary duty was not tried by the parties' implied consent. According to defendants, whether PacificSource violated the notice requirements of 29 CFR § 2560.503-1(g)(1)(iii) during the claims review process was not tried by implied consent because all the evidence and arguments presented concerning provider eligibility were related to McHenry's claim for denial of benefits under 29 USC § 1132(a)(1)(B).

This court agrees that defendants had no notice that McHenry was alleging a breach of fiduciary duty in this context. While the parties addressed Hoyt's status as an eligible provider extensively in their cross motions for summary judgment, and even submitted supplemental briefing on the issue, they did not address the issue in the context of whether PacificSource committed notice violations, thereby breaching its fiduciary duty. Further, McHenry's position has always been that a provider who provides a covered benefit is eligible for reimbursement. Consequently, she brought a claim for benefits pursuant to 29 USC § 1132(a)(1)(B), asserting that ABA therapy is a covered benefit and that Hoyt is an eligible provider because she provides that ABA therapy.

To the extent that McHenry alleged a breach of fiduciary duty, it was in the context of whether a conflict of interest existed due to PacificSource's failure to notify the Oregon

Insurance Division ("OID") of IMEDECS' conflict of interest. *See* docket # 44, p. 35. Not until the court's summary judgment opinion was McHenry provided with the information she needed, and which PacificSource failed to provide, regarding the Plan's provider eligibility requirements. With that knowledge, McHenry promptly enrolled Hoyt with ODHS and filed her Motion for Reconsideration on the ground that, but for PacificSource's breach of its fiduciary duty during the claims review process, Hoyt would have been eligible for reimbursement under Oregon law much earlier. This was the first time that the notice requirements of 29 CFR § 2560.503-1(g)(1) became an issue. Accordingly, defendants would be prejudiced by adding a claim at this late date for breach of PacificSource's fiduciary notice obligation under 29 CFR § 2560.503-1(g)(1) which was not tried with all parties' informed consent. For this reason alone, McHenry cannot amend her complaint at this late date.

**C. <u>Futility</u>**

Defendants also contend that amendment would be futile because McHenry has no basis for obtaining equitable relief under 29 USC § 1132(a)(3). As support, it argues that: (1) Hoyt did not, could not, and still does not satisfy the requirements to become an eligible provider under Oregon law; (2) McHenry has other avenues of relief that she has already pursued (based on Hoyt's prior qualifications) and may still pursue (based on Hoyt's purported new qualifications); (3) she seeks legal relief in the form of monetary damages; and (4) the proper remedy would be to remand the claim to PacificSource to determine Hoyt's eligibility as a provider based on new evidence. Although Hoyt is an eligible provider under Oregon law, this court agrees that McHenry cannot recover the relief alleged in the proposed amended complaint.

**1. <u>Hoyt's Status as an Eligible Provider</u>**

In support of her motion, McHenry submits three supporting affidavits to show that Hoyt possessed the requisite qualifications to be enrolled as an ODHS provider in January 2007 and would have been approved as a provider by ODHS if she had applied for provider status at that time.

First is the affidavit of Nita Cannon, Office Specialist with the CIIS program of ODHS, who reviewed Hoyt's qualifications in light of ODHS's requirements for providers in January 2007 and determined that nothing barred Hoyt from meeting ODHS's training, education and criminal history check requirements as of January 1, 2007. Cannon Aff. (docket # 85), ¶¶ 1, 2. If Hoyt had completed the Oregon Intervention System ("OIS") certification and obtained professional liability insurance, then "she would have been approved as a provider at that time." *Id*, ¶ 2.

Second is the affidavit of Cindy Hodges, a certified OIS trainer for the Northwest Regional Educational Services District Special Student Services. Hodges explains that the eligibility requirements to receive OIS training have not changed since January 2007. Hodges Aff. (docket # 84), ¶¶ 1, 6, 8. Although Hoyt completed her OIS training in early 2010, it was substantially the same OIS training that she would have received in January 2007 or any time thereafter. *Id* at ¶¶ 7-8.

Third is Hoyt's affidavit. She states that while she did not possess professional liability insurance in 2007, she could have and would have obtained that insurance had she been asked to do so in order to participate in OIS training or become an enrolled provider through ODHS. Hoyt Aff. (docket # 86), ¶¶ 1-4.

In response, defendants argue that this court has already decided that McHenry failed to

establish Hoyt was an eligible provider from January 10, 2007, through March 31, 2010. Therefore, any benefits for services provided by Hoyt during that time period would impermissibly require defendants to pay benefits for services not covered under the Plan. To avoid this result, McHenry asks the court to retroactively deem Hoyt to be an eligible provider. If this court entered such an order, then PacificSource would not be violating the terms of the Plan.

On the issue of Hoyt's status, the court has determined, as discussed above, that she became an eligible provider under the terms of the Plan effective February 5, 2010, when she became authorized for reimbursement under Oregon law. That is sufficient to overcome PacificSource's concern about paying benefits in violation of the terms of the Plan as of that date. As for the time period before February 5, 2010, when McHenry has presented evidence that Hoyt could have become an eligible provider, McHenry cannot recover benefits as sought in her proposed amended complaint, as discussed below.

**2. <u>Nature of Relief Requested</u>**

Individual equitable relief for breach of fiduciary duty is available under 29 USC § 1132(a)(3)'s "catchall" provision only "for injuries caused by violations that § 502 does not elsewhere adequately remedy." *Varity Corp. v. Howe*, 516 US 489, 512 (1996). Moreover, the remedies available under this subsection are limited to those remedies that were "traditionally viewed as 'equitable,' such as injunction or restitution." *Mertens v. Hewitt Assocs.*, 508 US 248, 255 (1993). Thus, in order to have an actionable claim under § 1132(a)(3), a plaintiff must have no other adequate avenue of relief under ERISA and must seek relief that has traditionally been viewed as equitable. McHenry's proposed amended complaint fails on both accounts.

When another ERISA provision, such as 29 USC § 1132(a)(1)(B), provides an avenue for relief, a claimant may not pursue a claim for equitable relief under § 1132(a)(3). *Ford v. MCI Comm. Corp. Health and Welfare Plan*, 399 F3d 1076, 1083 (9th Cir 2005); *Forsyth v. Humana, Inc.*, 114 F3d 1467, 1475 (9th Cir), *cert denied*, 522 US 996 (1997), *cert granted*, 524 US 936 (1998), *aff'd*, 525 US 299 (1999). Defendants contend that McHenry's requested payment of benefits after January 10, 2007, is really a benefits claim disguised in equitable language. This court agrees.

McHenry's original claim sought to recover benefits due under the Plan, and she has presented no evidence that her ability to seek benefits under § 1132(a)(1)(B) has been foreclosed.[3] In fact, her proposed amended complaint seeks damages under § 1132(a)(1)(B) in addition to various forms of injunctive relief under § 1132(a)(3). Thus, a claim by McHenry for equitable relief is inappropriate because the relief available under § 1132(a)(1)(B) is adequate to address her claim for payment of benefits for the ABA therapy provided by Hoyt. *Varity*, 516 US at 512; *see also*, *Ford*, 399 F3d at 1082 (holding that because plaintiff had asserted claims under discrete ERISA provisions, including § 1132(a)(1)(B), the "catchall" provision of § 1132(a)(3) was not available); *Forsyth*, 114 F3d at 1475 (holding that employee beneficiaries could not bring claim under § 1132(a)(3) where they had a claim under § 1132(a)(3)).

Moreover, it is clear that McHenry seeks monetary damages, not equitable relief. The term "equitable relief" in 29 USC § 1132(a)(3) "must refer to 'those categories of relief that were typically available in equity . . . .'" such as injunction, mandamus, and restitution. *Great-West*

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[3] McHenry does not directly address whether she can still bring a benefits claim for the ABA therapy provided over three years ago. Defendants assert that McHenry can still pursue her claim. Thus, the court presumes that there are no additional obstacles to pursuing such a claim, such as a time bar or other procedural hurdles. *See* Def.'s Supp. Memo. (docket #93), p. 7.

*Life & Annuity Ins. Co. v. Knudson*, 534 US 204, 210 (2002), citing *Mertens*, 508 US at 256; *see also*, *FMC Med. Plan v. Owens*, 122 F3d 1258, 1261 (9th Cir 1997). Relief under § 1132(a)(3) is not appropriate when a claim for monetary relief is disguised in equitable language. *Paulsen v. CNF Inc.*, 559 F3d1061, 1076 (9th Cir 2009), *cert. denied*, 130 S Ct 1053 (2010); *Reynolds Metals Co. v. Ellis*, 202 F3d 1246, 1248 (9th Cir), *cert. granted*, 531 US 1009, *cert. dismissed*, 531 US 1061 (2000). Although the proposed amended complaint seeks injunctive and declaratory relief, McHenry requests the court to prevent PacificSource from denying her claim, ultimately resulting in payment of benefits. *See Knudson*, 534 US at 210 ("'[a]lmost invariably . . . suits seeking (whether by judgment, injunction, or declaration) to compel the defendant to pay a sum of money to the plaintiff are suits for 'money damages,' as that phrase has traditionally been applied, since they seek no more than compensation for loss resulting from the defendant's breach of legal duty.'"), quoting *Bowen v. Mass.*, 487 US 879, 918-19 (1988) (Scalia, J., dissenting).

To the extent that McHenry seeks restitution, the Supreme Court has stated that "for restitution to lie in equity, the action generally must seek not to impose personal liability on the defendant, but to restore to the plaintiff particular funds or property in the defendant's possession." *Knudson*, 534 US at 214. Moreover, restitution is measured by a defendant's "unjust gain, rather than [by a plaintiff's] loss." *Id* at 229 (Ginsburg, J., dissenting). Here, it is clear that McHenry seeks to recover funds attributable to her loss through recovery of payment for J.M.'s ABA therapy. McHenry seeks a declaratory order requiring the payment of benefits in the amount of more than $50,000.00. No matter how she attempts to characterize it, the heart of this claim is one for payment of benefits due under the Plan. "When the substance of the relief is monetary . . . such a remedy is not available under section 1132(a)(3)." *Owens*, 122 F3d at 1262;

*see also*, *Knudson*, 534 US at 221 ("Because petitioners are seeking legal relief – the imposition of personal liability on respondents for a contractual obligation to pay money – § 1132(a)(3) does not authorize this action."). McHenry's attempt to characterize her claim for declaratory relief as a necessary step in awarding benefits is not supported by the case law. While the cases she cites may contain some favorable language, they do not change the rule that equitable relief under § 1132(a)(3) does not include compensatory damages and is not appropriate where another section provides an adequate remedy. Accordingly, amendment of the complaint to add a claim for breach of fiduciary duty seeking payment of benefits would be futile.

**D. Conclusion**

McHenry's Motion for Leave to File First Amended Complaint (docket #76) is denied. The amendment would be prejudicial to defendants because the issue of whether PacificSource breached its fiduciary notice obligations was not tried by the parties' informed consent. Moreover, the amendment would be futile because McHenry has no basis for obtaining equitable relief under 29 USC § 1132(a)(3) and seeks legal relief in the form of monetary damages.

## III. Relief

Although this court has previously concluded, and still concludes, that PacificSource breached its fiduciary duty to McHenry, McHenry cannot recover any equitable relief as a result. However, this court also has concluded that ABA therapy is a covered benefit under the Plan and that Hoyt became an eligible provider effective February 5, 2010. The remaining issue is what relief should be awarded as a result. In her proposed amended complaint, McHenry requests that the court: (1) issue a declaration that Hoyt is an eligible provider authorized for reimbursement under the Plan, effective January 10, 2007, and (2) order defendants to process her claims for

ABA therapy provided by Hoyt. Although McHenry may not amend her complaint to seek this relief, her initial complaint is sufficient to include a claim for benefits as early as January 2007 when, based on the newly presented evidence, Hoyt could have become an eligible provider.

**A. Retroactive Reimbursement**

The court declines to retroactively declare Hoyt eligible for reimbursement under Oregon law prior to February 5, 2010, because McHenry has cited no case, and the court is aware of none, that permits such a remedy in circumstances such as these. Moreover, even if Hoyt could have enrolled as a Behavior Consultant under the CIIS Program as early as January 10, 2007, the fact remains that she did not do so and, therefore, was not subject to any ODHS oversight at that time.

**B. Remand**

Rather than award benefits to McHenry, defendants argue that the proper remedy is to remand the claim to PacificSource, as the claims administrator, to determine the eligibility of McHenry's provider based on new evidence outside the administrative record that had not been presented to or considered by PacificSource.

Where the plan administrator wrongfully terminated benefits, "retroactive reinstatement of benefits is appropriate in ERISA cases where . . . but for [the insurer's] arbitrary and capricious conduct, [the insured] would have continued to receive the benefits or where there [was] no evidence in the record to support a termination or denial of benefits." *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F3d 1154, 1163 (9th Cir 2001) (internal citations omitted). In contrast, a "[r]emand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied the wrong standard to a benefits determination." *Saffle v. Sierra Pac. Power Co. Bargaining Unit*

*Long Term Disability Income Plan*, 85 F3d 455, 461 (9th Cir 1996). "This distinction in remedies makes perfect sense, as the improper termination . . . was the result of arbitrary and capricious procedures, and therefore [ ]benefits could not have been terminated by those procedures." *Pannebecker v. Liberty Life Ass. Co. of Boston*, 542 F3d 1213, 1221 (9th Cir 2008) (citation and internal quotation omitted). The Sixth Circuit has interpreted *Grosz-Salomon* to mean that "where a plan administrator properly construes the plan documents but arrives at the 'wrong conclusion' that is 'simply contrary to the facts,' a court should award benefits." *Shelby County Health Care Corp. v. Majestic Star Casino*, 581 F3d 355, 374-75 (6th Cir 2009), quoting *Grosz-Salomon*, 237 F3d at 1163.

This case does not involve an improper termination of benefits due to arbitrary and capricious procedures or a situation where the administrator properly construed the plan documents but arrived at the wrong conclusion. Instead, PacificSource improperly construed the Plan documents and denied McHenry's claim because ABA therapy was not a covered benefit and Hoyt was not an eligible provider. While there is evidence in the record that but for PacificSource's failure to provide McHenry with the information necessary to perfect her provider eligibility claim, Hoyt could have and would have enrolled with ODHS earlier, this was not the result of any arbitrary or capricious procedure. Instead, PacificSource did not consider ABA therapy a covered benefit. Whether Hoyt was an eligible provider was a secondary issue; unless she was providing a covered benefit, then it would not pay the claim. *See* SR 105, 212. While the court later disagreed, PacificSource's position was not unreasonable at the time. *See Tinker v. Versata Inc. Group Disability Income Ins. Plan*, 566 F Supp 2d 1158, 1167 (ED Cal 2008) (finding an administrator's termination of a disability claim was unreasonable, thereby

entitling the claimant to a reinstatement of benefits). Moreover, Hoyt was not enrolled with ODHS at the time of the denial, such that PacificSource's denial was not contrary to the facts, but rather, was consistent with the facts as they existed at that time.

Remand also is appropriate when new evidence relating to a benefits claim is introduced at trial that was not previously considered by a plan administrator exercising discretion. *Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F3d 120, 125 (4th Cir 1994). However, when the plan administrator is not granted discretion and the court conducts a *de novo* review of a plan administrator's decision, the court may consider evidence not taken into account by the administrator. *Id*. Here the Plan did not confer a broad grant of discretionary authority to PacificSource to determine claims, and review is *de novo* (docket #27). The court previously found that ABA therapy was a covered benefit under the Plan and that Hoyt is an eligible provider under the terms of the Plan as of February 5, 2010. Thus, based upon the fully developed record currently before the court, it is clear that under the terms of the 2007 Plan, McHenry is authorized for reimbursement for the ABA therapy provided by Hoyt since February 5, 2010.

Defendants also argue that remand is appropriate because some of the bills submitted by McHenry require further evaluation. For example, several of the bills are from providers other than Hoyt. *See, e.g.*, McHenry Aff. (docket #87), Ex. A, at pp. 21-23, 26, 29, 32, 35, 38, 41, 43-45, 53, 63, 65, 67-69, 71-72, 74, 76, 78. The bills also contain some unusual entries, such as those entitled "tuition," "gas expenses," and "Vegas," that may require further evaluation. *Id* at 47, 51, 54, 55. However, the court may accomplish this same result by having the parties submit a stipulated statement of benefits payable under the Plan. *See Lafferty v. Providence Health*

*Plans*, Civil No. 08-6318-TC, — F Supp2d —, 2010 WL 1499460, at * 16 (D Or April 12, 2010).

Given PacificSource's previous failure to fully comply with the notice requirements of 29 CFR § 2560.503-1(g)(1)(iii), it will not be afforded a "second bite at the apple" with a remand of McHenry's claim. *Grosz-Salomon*, 237 F3d at 1163. Moreover, remand would result in further delay on a claim for treatment that began over three years ago. Consequently, McHenry is entitled to reimbursement for ABA therapy provided by Hoyt, effective February 5, 2010, and defendants are directed to process McHenry's claims for ABA therapy provided by Hoyt on and after that date.

## IV. Bill of Costs

Defendants submitted a Bill of Costs (docket #61) pursuant to this court's earlier judgment granting summary judgment in its favor. FRCP 54(d)(1) provides, in part, that "costs other than attorneys' fees shall be allowed as of course to the prevailing party unless the court otherwise directs[.]" However, "the discretion granted under Rule 54(d) allows a court to decline to tax costs." *Adidas America, Inc. v. Payless Shoesource, Inc.*, Civil No. 01-1655-KI, 2009 WL 302246, at *2 (D Or Feb. 6, 2009), quoting *Crawford Fitting Co. v. J.T. Gibbons, Inc.*, 482 US 437, 442 (1987). After defendants filed their Bill of Costs, the court reconsidered its prior ruling. As a result, McHenry has achieved partial recovery on her claim for benefits that this court had previously denied in full. Because McHenry is also a "prevailing party" in this action, this court declines to award the costs requested by defendants.

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## ORDER

Based on the above, defendants' Bill of Costs (docket #61), defendants' Motion for Amendment of Findings and Judgment (docket #94), and McHenry's Motion for Leave to File an Amended Complaint (docket #76) are DENIED, and McHenry's Motion for Reconsideration (docket #64) is GRANTED to the extent that McHenry is entitled to reimbursement under the 2007 Plan for ABA therapy provided by Hoyt to J.M. on and after February 5, 2010, and is otherwise DENIED.

In order for this court to enter an amended judgment in McHenry's favor with respect to awarding past due benefits, within 28 days the parties shall submit to the court a stipulated statement of past due benefits payable to McHenry from February 5, 2010, to the date this Opinion and Order is filed.

DATED this 28th of September, 2010.

s/ Janice M. Stewart_______________
Janice M. Stewart
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

PORTLAND DIVISION

LISA A. MCHENRY,

Plaintiff,

v.

PACIFICSOURCE HEALTH PLANS and THE METRO AREA COLLECTION SERVICE, INC. GROUP HEALTH/DENTAL PLAN,

Defendants.

CV-08-562-ST

SUPPLEMENTAL JUDGMENT

STEWART, Magistrate Judge:

Based on the record, it is hereby ORDERED and ADJUDGED that plaintiff shall recover from defendants the sum of $211,942.50 for her attorney fees in addition to costs taxed in the sum of $816.00.

DATED this 30th day of August, 2011.

s/ Janice M. Stewart
Janice M. Stewart
United States Magistrate Judge