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For Public Release

November 14, 2014

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

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

Dear Laura,

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

Questions and Short Answers

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

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

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

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

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

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

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

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

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

Applicable Statutes and Regulations

The questions in this letter relate to:

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

Discussion

1. What does the provision grandfathering ABA providers mean?

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

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

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

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

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

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

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

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

A. Who is grandfathered?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[9] 29 USC 1185a.

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

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

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

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

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

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

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

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

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

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

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

> A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder *all medical services, including rehabilitation services*, that are medically necessary and are otherwise covered under the plan.

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

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

[12] 45 CFR §146.136(c).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regards,

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Attorney-in-Charge

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