

1 CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION
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6 CALIFORNIA DEPARTMENT OF INSURANCE

7
8 **BEFORE THE INSURANCE COMMISSIONER**
9 **OF THE STATE OF CALIFORNIA**

10
11 In the Matter of

12 BLUE SHIELD OF CALIFORNIA LIFE
AND HEALTH INSURANCE CO.,

13
14 Respondent.

File No. UPA-2011-00001

**ORDER TO SHOW CAUSE AND
STATEMENT OF CHARGES; NOTICE
OF MONETARY PENALTY; NOTICE OF
FILING WITH AGENCY**

(California Insurance Code §§790.03, 704,
700(c),790.035 and Government Code §11505)

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17 **ORDER TO SHOW CAUSE**

18 WHEREAS, the Insurance Commissioner of the State of California (hereafter, "the
19 Commissioner") has reason to believe that Blue Shield of California Life and Health Insurance
20 Company (hereinafter "Respondent") has engaged in or is engaging in this State in unfair
21 methods of competition or unfair or deceptive acts or practices set forth in the STATEMENT OF
22 CHARGES contained herein, in violation of Sections 790 et seq. of the California Insurance
23 Code and the Fair Claims Settlement Regulations of Title 10, Chapter 5, California Code of
24 Regulations; and

25 WHEREAS, the Commissioner has reason to believe that RESPONDENT has engaged in
26 conduct in violation of California's Mental Health Parity Act, CIC Section 10144.5; and

27 WHEREAS, the Commissioner believes that a proceeding with respect to the alleged acts
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1 of RESPONDENT would be in the public interest;

2 NOW, THEREFORE, and pursuant to the provisions of CIC Sections 790.05,
3 RESPONDENT is ordered to appear before the Commissioner on a date to be determined and
4 show cause, if any cause there be, why the Commissioner should not issue an Order requiring
5 RESPONDENT to Cease and Desist from engaging in the acts and practices set forth in the
6 STATEMENT OF CHARGES contained herein and imposing the penalties set forth in Section
7 790.035 of the Insurance Code and other Insurance Code sections as requested herein. Further,
8 Respondent is hereby ordered to show why the Commissioner should not exercise his authority
9 pursuant to Section 704 of the Insurance Code to suspend Respondent's Certificate of Authority
10 for a time not exceeding one year upon finding that Respondent has engaged in and is engaged in
11 not carrying out its contracts in good faith, in violation of Insurance Code Section 704(b).

12 **JURISDICTION AND PARTIES**

13 1. The California Department of Insurance (hereafter "Department") brings this
14 matter before the Commissioner pursuant to the provisions of Insurance Code §§790.05 and 704.

15 2. Respondent is, and at all relevant times has been, the holder of a Certificate of
16 Authority issued by the Commissioner and is authorized to transact the business of insurance in
17 California.

18 **STATUTES AND REGULATIONS**

19 3. Insurance Code § 704(b) provides that the Department may suspend an insurer's
20 certificate of authority, after hearing, for not carrying out its contracts in good faith.

21 4. Insurance Code § 790.03(h) enumerates sixteen (16) claims settlement practices
22 that, when either knowingly committed on a single occasion, or performed with such frequency as
23 to indicate a general business practice, are considered to be unfair claims settlement practices, and
24 are thus prohibited.

25 5. Insurance Code § 790.03(h)(1) prohibits insurers from misrepresenting to
26 claimants pertinent facts or insurance policy provisions relating to any coverages contained in the
27 contract.

28 6. Insurance Code § 790.03(h)(2) prohibits insurers from failing to acknowledge and

1 act reasonably promptly upon communications with respect to claims arising under their
2 insurance policies.

3 7. Insurance Code § 790.03(h)(3) prohibits insurers from failing to adopt and
4 implement reasonable standards for the prompt investigation and processing of claims arising
5 under insurance policies.

6 8. Insurance Code § 790.03(h)(4) requires that insurers affirm or deny coverage of
7 claims within a reasonable time after proof of loss requirements have been completed and
8 submitted by the insured.

9 9. Insurance Code § 790.03(h)(5) requires that insurers exercise good faith to
10 effectuate prompt, fair, and equitable settlements of claims in which liability has become
11 reasonably clear.

12 10. Insurance Code § 790.035 provides that “any person who engages in any unfair
13 method of competition or any unfair or deceptive act or practice defined in § 790.03 is liable to
14 the state for a civil penalty to be fixed by the Commissioner, not to exceed five thousand dollars
15 (\$5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten
16 thousand dollars (\$10,000) for each act. The Commissioner shall have the discretion to establish
17 what constitutes an act.”

18 11. Insurance Code § 10123.13(a) requires that “[e]very insurer issuing group or
19 individual policies of health insurance that covers hospital, medical, or surgical expenses,
20 including those telemedicine services covered by the insurer as defined in subdivision (a) of
21 Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of
22 any claim, whether in state or out of state, for those expenses as soon as practical, but no later
23 than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof
24 is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim
25 is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice
26 that a claim is being contested or denied shall identify the portion of the claim that is contested or
27 denied and the specific reasons including for each reason the factual and legal basis known at that
28 time by the insurer for contesting or denying the claim. If the reason is based solely on facts or

1 solely on law, the insurer is required to provide only the factual or the legal basis for its reason for
2 contesting or denying the claim. The insurer shall provide a copy of the notice to each insured
3 who received services pursuant to the claim that was contested or denied and to the insured's
4 health care provider that provided the services at issue. The notice shall advise the provider who
5 submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of
6 payment and the insured that either may seek review by the Department of a claim that the insurer
7 contested or denied, and the notice shall include the address, Internet Web site address, and
8 telephone number of the unit within the Department that performs this review function. The
9 notice to the provider may be included on either the explanation of benefits or remittance advice
10 and shall also contain a statement advising the provider of its right to enter into the dispute
11 resolution process described in Insurance Code § 10123.137. The notice to the insured may also
12 be included on the explanation of benefits.”

13 12. Insurance Code § 10144.5, California’s Mental Health Parity Act (hereafter
14 “MHPA”), provides as follows:

15 (a) Every policy of disability insurance that covers hospital, medical, or surgical
16 expenses in this state that is issued, amended, or renewed on or after July 1, 2000,
17 shall provide coverage for the diagnosis and medically necessary treatment of
18 severe mental illnesses of a person of any age, and of serious emotional
19 disturbances of a child, as specified in subdivisions (d) and (e), under the same
20 terms and conditions applied to other medical conditions, as specified in
21 subdivision (c).

22 (b) These benefits shall include the following:

23 (1) Outpatient services.

24 (2) Inpatient hospital services.

25 (3) Partial hospital services.

26 (4) Prescription drugs, if the policy or contract includes coverage for
27 prescription drugs.
28

1 (c) The terms and conditions applied to the benefits required by this section that
2 shall be applied equally to all benefits under the disability insurance policy shall
3 include, but not be limited to, the following:

- 4 (1) Maximum lifetime benefits.
- 5 (2) Copayments and coinsurance.
- 6 (3) Individual and family deductibles.

7 (d) For the purposes of this section, "severe mental illnesses" shall include:

- 8 (1) Schizophrenia.
- 9 (2) Schizoaffective disorder.
- 10 (3) Bipolar disorder (manic-depressive illness).
- 11 (4) Major depressive disorders.
- 12 (5) Panic disorder.
- 13 (6) Obsessive-compulsive disorder.
- 14 (7) Pervasive developmental disorder or autism.
- 15 (8) Anorexia nervosa.
- 16 (9) Bulimia nervosa.

17 13. Insurance Code § 10169.3(f) provides that "[t]he commissioner shall immediately
18 adopt the determination of the independent medical review organization, and shall promptly issue
19 a written decision to the parties that shall be binding on the insurer."

20 14. California Code of Regulations ("CCR"), Title 10, Chapter 5, Subchapter 7.5,
21 Article 1 contains the Fair Claims Settlement Practices Regulations "to promote the good faith,
22 prompt, efficient and equitable settlement of claims." These regulations delineate certain
23 minimum standards for the settlement of claims which, when violated knowingly on a single
24 occasion or performed with such frequency as to indicate a general business practice, shall
25 constitute an unfair claims settlement practice within the meaning of Insurance Code § 790.03(h).
26 Other acts or practices not specifically delineated in this set of regulations may also be unfair
27 claims settlement practices subject to Insurance Code § 790.03. All licensees are required to have
28 thorough knowledge of such regulations.

1 15. CCR, Title 10, § 2695.5(b) provides that “[u]pon receiving any communication
2 from a claimant, regarding a claim, that reasonably suggests that a response is expected, every
3 licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of
4 that communication, furnish the claimant with a complete response based on the facts as then
5 known by the licensee. This subsection shall not apply to require communication with a claimant
6 subsequent to receipt by the licensee of a notice of legal action by that claimant.

7 16. CCR, Title 10, § 2695.5(e) provides that “[u]pon receiving notice of a claim, every
8 insurer shall immediately, but in no even more than fifteen (15) calendar days alter, do the
9 following unless the notice of claim received is a notice of legal action:

10 (1) acknowledge receipt of such notice to the claimant unless payment is made
11 within that time period. If the acknowledgement is not in writing, a notation of
12 acknowledgement shall be made in the insurer's claim file and dated. ...

13 (2) provide to the claimant necessary forms, instructions, and reasonable
14 assistance, including but not limited to, specifying the information the claimant
15 must provide for proof of claim;

16 (3) begin any necessary investigation of the claim.”

17 17. CCR, Title 10, § 2240(a)(7) defines basic health care services:

18 (a) “Basic health care services” means any of the following covered health care
19 services provided for in the applicable insurance contract or certificate of
20 coverage:

21 (1) Physician services, including consultation and referral.

22 (2) Hospital inpatient services and ambulatory care services.

23 (3) Diagnostic laboratory diagnostic and therapeutic radiologic services.

24 (4) Home health services.

25 (5) Preventive health services.

26 (6) Emergency health care services, including ambulance services.

27 (7) Mental health care services including those intended to meet the
28 requirements of Insurance Code 10144.5.

1 (8) Any other health care or supportive services that are covered pursuant
2 to an insurance contract.

3 18. CCR, Title 10, § 2240.1 addresses the adequacy and accessibility of providers
4 required in an insurer's network:

5 (c) In arranging for network provider services, insurers shall ensure that:

6 (1) There is the equivalent of at least one full-time physician per 1,200
7 covered persons and at least the equivalent of one full-time primary care
8 physician per 2,000 covered persons.

9 (2) There are primary care network providers with sufficient capacity to
10 accept covered persons within 30 minutes or 15 miles of each covered
11 person's residence or workplace.

12 (3) There are medically required network specialists who are certified or
13 eligible for certification by the appropriate specialty board with sufficient
14 capacity to accept covered persons within 60 minutes or 30 miles of a
15 covered person's residence or workplace. Notwithstanding the above, the
16 Commissioner may determine that certain medical needs require network
17 specialty care located closer to covered persons when the nature and
18 frequency of use of such health care services, and the standards of
19 Insurance Code 10133.5(b) (3), support such modification.

20 (4) There are mental health professionals with skills appropriate to care for
21 the mental health needs of covered persons and with sufficient capacity to
22 accept covered persons within 30 minutes or 15 miles of a covered person's
23 residence or workplace.

24 19. Insurance Code § 10169(d)(3) provides that "[t]he Department shall be the final
25 arbiter when there is a question as to whether an insured grievance is a disputed health care
26 service or a coverage decision... If there appears to be any medical necessity issue, the grievance
27 shall be resolved pursuant to an independent medical review as provided under this article."

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1 **BACKGROUND**

2 20. AB is an 8 year old female who was diagnosed with autism. AB's child
3 psychiatrist prescribed Applied Behavioral Analysis ("ABA") therapy as a medically necessary
4 therapeutic intervention. AB's father contacted Respondent in or about November 2010 to verify
5 benefits and coverage for AB. Her doctor's prescription for ABA therapy was denied by
6 Respondent. Autism is a neurologic condition for which ABA therapy is a well-established,
7 evidence-based treatment. It is considered the standard of care for autism.

8 21. BL is a 5 year old male diagnosed with autism. As part of his treatment, his
9 pediatrician prescribed medically necessary ABA therapy. BL's mother contacted Respondent in
10 September 2010 in an attempt to verify coverage of the prescribed ABA therapy. After multiple
11 attempts by BL's mother to obtain a written response from Respondent, BL's coverage was
12 verbally denied by telephone.

13 22. Both AB and BL requested Independent Medical Review (IMR) from the
14 Department. Pursuant to § 10169, IMR is available to obtain an independent doctor's review of
15 the circumstances of each individual's case and a determination of whether the disputed health
16 care service is medically necessary.

17 23. In each case, doctors who conducted the independent medical reviews and who
18 have special qualifications in the area of autism such as child neurology and clinical
19 neurophysiology, found that the prescribed ABA therapy was medically necessary. As required
20 by law, the Commissioner immediately adopted the IMR Decision and immediately notified
21 Respondent, and requested that the medically necessary services be provided and paid for.

22
23 **STATEMENT OF CHARGES**

24
25 **A. Improper Denial of Coverage on the Ground ABA Therapy Is Not "Medically
26 Necessary"**

27 24. On June 3, 2011, the Department issued a request to Respondent for a listing of the
28 in-network ABA therapy providers accessible to its insureds with PPO health insurance coverage.

1 25. In its June 20, 2011 response to the Department's data call, Respondent identified
2 the basis on which it believed ABA therapy was excluded from its policy coverage. Respondent
3 stated that it denies medically necessary ABA therapy on the grounds "that the policies do not list
4 ABA as a covered service under any category," "that there is no comparable service that is
5 covered for medical conditions," and "that ABA therapy is more generally considered a
6 behavioral therapy."

7 26. Medically necessary ABA therapy is a mandated outpatient service under the
8 MHPA 10144.5(a) and (b) (1). Autism is one of the listed severe mental illnesses for which
9 Respondent is required to provide outpatient services if such treatment is medically necessary.

10 27. As a matter of systematic company practice, Respondent continues to assert false
11 grounds for denying coverage of medically necessary ABA therapy in spite of the many IMR
12 decisions in which the reviewing doctor identified ABA therapy as a medical service for the
13 medical condition of autism, confirming the insured's doctor's prescription.

14 28. Respondent violates the MHPA and 790.03(h)(1) by denying coverage on the
15 ground that ABA categorically is not medically necessary and refusing to inform its insureds that
16 its mental health policy provisions cover medically necessary ABA therapy.

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18 **B. Improper Denial of Coverage on the Ground ABA Therapy Is
19 "Experimental"**

20 29. In or about November 2010, AB contacted Respondent seeking verification of
21 coverage for the medically necessary ABA therapy prescribed by AB's psychiatrist. Respondent
22 advised AB that coverage was denied on the grounds that ABA "is still considered an
23 experimental treatment". AB called Respondent several times, and each time, Respondent
24 restated this reason for denying coverage.

25 30. In subsequent phone calls, Respondent confirmed that other outpatient therapy
26 would be a covered benefit, if medically necessary, but continued to deny ABA therapy, claiming
27 it was experimental, and therefore not covered.

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1 31. ABA therapy has been in existence for several decades and has been broadly used
2 as an important proven therapeutic intervention for autistic children. ABA therapy is widely
3 understood by the medical community as the standard of care for autistic children.

4 32. Respondent improperly denied AB's request for coverage of ABA therapy for
5 AB's autism on the grounds that it was experimental, in violation of Section 10144.5(a) and
6 790.03(h)(1).

7 33. AB subsequently applied to the Department and requested an Independent Medical
8 Review "IMR" of the denied coverage. In response to AB's request for an IMR, Respondent
9 asserted that the denial was based on lack of coverage, not medical necessity.

10 34. Notwithstanding the wrongful denial by Respondent and the improper ground for
11 denial, Section 10169(d)(3) provides that " the Department shall be the final arbiter when there is
12 a question as to whether an insured grievance is a disputed health care service or a coverage
13 decision." Acting well within its statutory authority, the Department determined that this
14 grievance was a disputed health care service.

15 **C. Improper Denial of Coverage on the Ground ABA Therapy Must Be**
16 **Provided by a State- Licensed Provider**

17 35. On January 28, 2011, after being ordered by the Commissioner to cover and pay
18 for BL's medically necessary ABA therapy, Respondent continued to refuse to cover and pay for
19 treatment asserting "that his health plan excluded coverage for treatment by providers who are not
20 licensed in California," "it is a crime for anyone who is not licensed to provide treatment for a
21 medical condition " and finally, "because California does not license ABA providers, they are not
22 considered mental health care providers."

23 36. On February 18, 2011, Respondent denied AB's appeal and asserted two bases for
24 refusing coverage. Respondent stated " the clinical rationale for the denial is that the available
25 documentation does not support the conclusion that the services are being provided directly by an
26 individual or entity that is licensed or certified by the state to provide health care services, or is
27 not operating within the scope of such license or certification. . . Additionally, ABA is generally
28 considered to be behavioral, not medical therapy."

1 37. The state of California does not offer a state license for providers of ABA therapy,
2 thereby making it impossible for ABA therapists to secure a license. ABA therapists typically
3 obtain private certification called Board Certified Behavior Analyst® (“BCBA”) from the
4 Behavioral Analysis Certification Board (“BACB”). California State law and regulations
5 recognize the value of BCBA certification in Gov. Code §95021 and CCR, Title 17, §54382(8) &
6 (11), which provide for state approval of payment for ABA therapy provided by BCBA
7 therapists.

8 38. Respondent also rejects the supervisory model of the provision of ABA therapy
9 services whereby a state-licensed clinician oversees the creation and implementation of a
10 treatment plan which includes ABA therapy administered by non-state licensed ABA therapists.
11 Said rejection is arbitrary, without legal basis, and a violation of the MHPA and § 790.03(h)(1)
12 since Respondent repeatedly and as a matter of company policy, misrepresents pertinent facts
13 pertaining to its insurance coverage for autistic insureds.

14 39. On February 22, 2011 the Department contacted Respondent regarding its refusal
15 to cover BL’s medically necessary ABA therapy and explained that there is no state law
16 requirement that ABA therapists be state-licensed and further that there is no state law barring the
17 provision of medically necessary ABA therapy services under the supervision of a licensed
18 clinician.

19 40. On March 3, 2011, almost two months after the IMR Decision ordering
20 Respondent to cover medically necessary ABA therapy for BL, Respondent issued a letter to the
21 Department refusing to comply with the IMR decision and the Commissioner’s order on the
22 grounds that the ABA therapy provider selected by BL’s doctor had not submitted a “signed
23 certification verifying that the provider performing the services is a mental health care clinician
24 licensed by the state of California and providing services within the scope of that license.”

25 41. Respondent improperly denied coverage of ABA therapy to both AB and BL on
26 the ground that its providers do not have state licenses. A denial of mandated coverage based on
27 improper grounds is a misrepresentation of the policy provisions and a violation of MHPA and
28 §790.03(h)(1).

1 42. Respondent knowingly failed to attempt in good faith to effectuate prompt, fair
2 and equitable settlement of BL and AB's claims for medically necessary ABA therapy by
3 continuing to deny coverage on the grounds that ABA therapists require non-existent state
4 licenses and that they could not legally operate under the supervision of a state-licensed clinician,
5 in violation of §790.03(h)(5).

6 43. In spite of the Department's statement of its expectation that Respondent honor the
7 IMR Organization's medical necessity decision and the Department's adoption of that decision,
8 as required by law, and that the decision was binding on Respondent, Respondent continued to
9 delay coverage of BL's medically necessary ABA therapy in violation of §10169.3(f) and the
10 MHPA.

11 44. BL requested and received an IMR of the denied coverage. Respondent disputed
12 the Department's approval of BL's request for an IMR asserting that the denied coverage was
13 based on an exclusion clause.

14 45. Notwithstanding the wrongful denial by Respondent and the improper ground for
15 denial, §10169(d)(3) provides that " the Department shall be the final arbiter when there is a
16 question as to whether an insured grievance is a disputed health care service or a coverage
17 decision." Acting within its statutory authority, the Department determined that this grievance
18 was a disputed health care service.

19
20 **D. Improper Denial of Coverage on the Grounds ABA Therapy Is Not a Health**
21 **Care Service and Is Excluded as a Service for Learning Disabilities or as**
22 **Social Skills Therapy**

23 46. On February 18, 2011, Respondent wrote that AB's medically necessary ABA
24 therapy was excluded from coverage by Respondent's characterization of ABA therapy as
25 services: "for learning disabilities or behavioral problems or social skills training/ therapy."

26 47. On November 10, 2010, Respondent denied ABA therapy to BL primarily on the
27 grounds that the therapy was for learning disabilities and social skills training.

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1 48. Although ABA therapy can be characterized as behavior therapy, that is not its
2 sole function. In fact is commonly and properly prescribed as a medical service in the treatment
3 of a medical condition and is medically necessary in most cases.

4 49. Respondent's mischaracterization of medically necessary ABA therapy as
5 exclusively behavioral therapy, and therefore not covered, violates the MHPA and § 790.03(h)(1)
6 because it misrepresents pertinent facts concerning policy coverages.

7 50. Notwithstanding the wrongful denial by Respondent and the improper ground for
8 denial, Section 10169(d)(3) provides that " the Department shall be the final arbiter when there is
9 a question as to whether an insured grievance is a disputed health care service or a coverage
10 decision." Acting well within its statutory authority, the Department determined that this
11 grievance was a disputed health care service.

12
13 **E. Failure to Provide In-Network ABA Therapy Providers As Required by
14 Provider Network Access Regulations**

15 51. On June 3, 2011, the Department issued a request to Respondent for a listing of the
16 in-network ABA therapy providers accessible to its insureds with PPO health insurance coverage.

17 52. On June 20, 2011, Respondent replied to the Department's data request.
18 Respondent admitted it had no network of ABA therapy providers in violation of 10 CCR §
19 2240(a)(7) and § 2240.1(c)(4).

20 53. By failing to offer in-network coverage of ABA therapy services, Respondent
21 arbitrarily forces its insureds to receive a reduced out-of-network benefit for these mandated
22 mental health services, in violation of the MHPA.

23 **F. Failure Timely to Provide Statutorily-Required Written Responses When
24 Notified of a Claim**

25 54. On or about September 2010, BL's parents called Respondent to obtain pre-
26 authorization and verification of coverage for the prescribed ABA therapy for BL.

27 55. Respondent denied coverage of BL's medically necessary ABA therapy and
28 refused to provide a written **denial** of coverage in violation of 10 CCR §2695.5(b) knowing that
BL needed a written denial in order to file a request for an IMR with the Department.

1 56. After numerous attempts to obtain a written denial, BL's parents were forced to
2 make a HIPAA request from Respondent to obtain the voice/telephone records of their
3 conversations with Respondent.

4 57. Respondent received Notice of a Claim, as defined in 10 CCR §2695.2(n), when
5 AB and BL made oral notifications to Respondent that reasonably apprised them of BL's wish to
6 make a claim against the policies issued by Respondent with respect to the insurer's policy
7 provisions covering mental health services prescribed for treatment of their autism.

8 58. Using the voice records of BL's calls to the Respondent, BL filed request for an
9 IMR with the Department in an effort to obtain an independent professional review of the medical
10 necessity of ABA therapy that had been prescribed for treatment of his symptoms of autism.

11 59. Respondent delayed issuing a written denial of coverage of BL's medically
12 necessary ABA therapy until November 9, 2010 in violation of 10 CCR §2695.5(b) and Section
13 10123.13(a) which requires a written denial within 30 working days of notice of a claim.

14 60. Respondent knowingly violated the well-established claims handling and appeals
15 process by refusing to issue a written denial of coverage thereby delaying BL's ability to request
16 the IMR, and in so doing violated 10123.13(a).

17 61. In spite of Respondent's objections to the Department's granting BL's IMR
18 request, an IMR was conducted and the Department issued the Report on January 17, 2011. The
19 report overturned Respondent's denial of coverage and found ABA therapy is the standard of care
20 for young autistic patients and was medically necessary.

21 62. Notwithstanding the wrongful denial by Respondent and the improper ground for
22 denial, Section 10169(d)(3) provides that " the Department shall be the final arbiter when there is
23 a question as to whether an insured grievance is a disputed health care service or a coverage
24 decision." Acting well within its statutory authority, the Department determined that this
25 grievance was a disputed health care service.

26 63. Since IMR decisions are binding on both parties and the Commissioner, the
27 Commissioner ordered Respondent to provide coverage and pay for BL's medically necessary
28 ABA therapy on January 17, 2011.

1 64. Following issuance of the January 17, 2011 IMR decision, Respondent persisted in
2 improperly denying coverage of medically necessary ABA therapy in violation of Section
3 10169.3(f) and the MHPA.

4 **STATEMENT OF GROUNDS FOR MONETARY PENALTY AND POTENTIAL**
5 **LIABILITY PURSUANT TO CIC §§790 *et seq* AND SUSPENSION OF CERTIFICATE**
6 **OF AUTHORITY PURSUANT TO CIC §704(b)**

7 65. The facts alleged above in Paragraphs 20 through 64 constitute grounds, under
8 CIC § 790.05, for the Insurance Commissioner to order Respondent to cease and desist from
9 engaging in such in such unfair acts or practices and to pay a civil penalty not to exceed five
10 thousand dollars (\$5,000) for each act, or if the act or practice was willful, a civil penalty not to
11 exceed ten thousand dollars (\$10,000) for each act as set forth under Section 790.035 of the
12 California Insurance Code

13 66. The facts alleged in Paragraphs 19 through 63 show that Respondent have failed to
14 carry out its contracts in good faith, constituting grounds for the Insurance Commissioner to
15 suspend the Certificate of Authority of RESPONDENT for a period not to exceed one year
16 pursuant to CIC § 704(b).

17
18 **REQUEST FOR ORDER AND MONETARY PENALTY**

19 WHEREFORE, Petitioner prays for judgment against Respondent as follows:

20 1. An Order to Cease and Desist from engaging in the methods, acts,
21 and practices set forth in the STATEMENT OF CHARGES as set forth above;

22 2. For acts in violation of Insurance Code Section 790.03 and the
23 regulations promulgated pursuant to Section 790.10 of the Insurance Code, as set forth
24 above, a civil penalty not to exceed five thousand dollars (\$5,000) for each act or, if the act
25 or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each
26 act;

27 3. For acts in violation of Section 704(b) of the California Insurance Code,
28 suspension of Respondent's certificate of authority for not exceeding one year.


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- 4. Full restitution or reimbursement for acts or omissions in violation of the above-cited provisions of law; and,
- 5. Costs incurred by the Department in bringing this action and any future costs to the Department to ensure compliance.

NOTICE OF FILING WITH AGENCY

Pursuant to Government Code §§11505 and 11506(e), the Department hereby files this ORDER TO SHOW CAUSE AND STATEMENT OF CHARGES; NOTICE OF MONETARY PENALTY; NOTICE OF FILING WITH AGENCY with the California Department of Insurance.

Dated: 7/12/11

CALIFORNIA DEPARTMENT OF INSURANCE
By 
Andrea Rosen
Staff Counsel