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

10 In the Matter of
11 UNITEDHEALTHCARE INSURANCE
12 COMPANY,
13 Respondent.

File No. UPA-2012-00017

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

(California Insurance Code Sections 790.03,
700(c), and 790.035)

14
15
16 **ORDER TO SHOW CAUSE**

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

24 WHEREAS, the Commissioner has reason to believe that Respondent has engaged in
25 conduct in violation of California's Mental Health Parity Act, Insurance Code Section 10144.5;
26 and
27

28 WHEREAS, the Commissioner believes that a proceeding with respect to the alleged acts

1 of Respondent would be in the public interest;

2 NOW, THEREFORE, and pursuant to the provisions of Insurance Code Sections
3 790.05, 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.
8

9 **JURISDICTION AND PARTIES**

10 1. The California Department of Insurance (hereafter "Department") brings this matter
11 before the Commissioner pursuant to the provisions of Insurance Code Section 790.05.

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

16 **STATUTES AND REGULATIONS**

17 3. Insurance Code Section 790.03(h) enumerates sixteen (16) claims settlement
18 practices that, when either knowingly committed on a single occasion, or performed with such
19 frequency as to indicate a general business practice, are considered to be unfair claims
20 settlement practices, and are thus prohibited.

21 4. Insurance Code Section 790.03(h)(1) prohibits insurers from misrepresenting to
22 claimants pertinent facts or insurance policy provisions relating to any coverage contained in
23 the contract.
24

25 5. Insurance Code Section 790.035 provides that "any person who engages in any
26 unfair method of competition or any unfair or deceptive act or practice defined in Section
27 790.03 is liable to the state for a civil penalty to be fixed by the Commissioner, not to exceed
28 five thousand dollars (\$5,000) for each act, or, if the act or practice was willful, a civil penalty

1 not to exceed ten thousand dollars (\$10,000) for each act. The Commissioner shall have the
2 discretion to establish what constitutes an act.”

3 6. Insurance Code Section 10123.13(a) requires that “[e]very insurer issuing group or
4 individual policies of health insurance that cover hospital, medical, or surgical expenses,
5 including those telemedicine services covered by the insurer as defined in subdivision (a) of
6 Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of
7 any claim, whether in state or out of state, for those expenses as soon as practical, but no later
8 than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof
9 is contested by the insurer, in which case the claimant shall be notified, in writing, that the
10 claim is contested or denied, within 30 working days after receipt of the claim by the insurer.
11 The notice that a claim is being contested or denied shall identify the portion of the claim that is
12 contested or denied and the specific reasons including for each reason the factual and legal basis
13 known at that time by the insurer for contesting or denying the claim. If the reason is based
14 solely on facts or solely on law, the insurer is required to provide only the factual or the legal
15 basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the
16 notice to each insured who received services pursuant to the claim that was contested or denied
17 and to the insured's health care provider who provided the services at issue. The notice shall
18 advise the provider who submitted the claim on behalf of the insured or pursuant to a contract
19 for alternative rates of payment, and the insured, that either may seek review by the Department
20 of a claim that the insurer contested or denied. The notice shall include the address, Internet
21 Web site address, and telephone number of the unit within the Department that performs this
22 review function. The notice to the provider may be included on either the explanation of
23 benefits or remittance advice and shall also contain a statement advising the provider of its right
24 to enter into the dispute resolution process described in Insurance Code Section 10123.137. The
25 notice to the insured may also be included on the explanation of benefits.”
26
27
28

1 7. Insurance Code Section 10144.5, California's Mental Health Parity Act (hereafter
2 "MHPA"), provides as follows:

3 (a) Every policy of disability insurance that covers hospital, medical, or surgical
4 expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide
5 coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a
6 person of any age, and of serious emotional disturbances of a child, as specified in subdivisions
7 (d) and (e), under the same terms and conditions applied to other medical conditions, as specified
8 in subdivision (c).
9

10 (b) These benefits shall include the following:

11 (1) Outpatient services.

12 (2) Inpatient hospital services.

13 (3) Partial hospital services.

14 (4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.
15

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

19 (1) Maximum lifetime benefits.

20 (2) Copayments and coinsurance.

21 (3) Individual and family deductibles.
22

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

24 (1) Schizophrenia.

25 (2) Schizoaffective disorder.

26 (3) Bipolar disorder (manic-depressive illness).

27 (4) Major depressive disorders.

28 (5) Panic disorder.

1 (6) Obsessive-compulsive disorder.

2 (7) Pervasive developmental disorder or autism.

3 (8) Anorexia nervosa.

4 (9) Bulimia nervosa.

5 8. Insurance Code Section 10169.3(f) provides that “[t]he commissioner shall
6 immediately adopt the determination of the independent medical review organization, and shall
7 promptly issue a written decision to the parties that shall be binding on the insurer.”

8
9 9. California Code of Regulations (“CCR”), Title 10, Chapter 5, Subchapter 7.5,
10 Article 1 contains the Fair Claims Settlement Practices Regulations “to promote the good faith,
11 prompt, efficient and equitable settlement of claims.” These regulations delineate certain
12 minimum standards for the settlement of claims which, when violated knowingly on a single
13 occasion or performed with such frequency as to indicate a general business practice, shall
14 constitute an unfair claims settlement practice within the meaning of Insurance Code Section
15 790.03(h). Other acts or practices not specifically delineated in this set of regulations may also
16 be unfair claims settlement practices subject to Insurance Code Section 790.03. All licensees
17 are required to have thorough knowledge of such regulations.
18

19 10. CCR, Title 10, Section 2695.5(b) provides that “[u]pon receiving any
20 communication from a claimant, regarding a claim, that reasonably suggests that a response is
21 expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days
22 after receipt of that communication, furnish the claimant with a complete response based on the
23 facts as then known by the licensee. This subsection shall not apply to require communication
24 with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.
25

26 11. CCR, Title 10, Section 2240(a)(7) defines basic health care services:

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

- 1 (1) Physician services, including consultation and referral.
- 2 (2) Hospital inpatient services and ambulatory care services.
- 3 (3) Diagnostic laboratory diagnostic and therapeutic radiologic services.
- 4 (4) Home health services.
- 5 (5) Preventive health services.
- 6 (6) Emergency health care services, including ambulance services.
- 7 (7) Mental health care services including those intended to meet the requirements of
- 8 Insurance Code 10144.5.
- 9
- 10 (8) Any other health care or supportive services that are covered pursuant to an insurance
- 11 contract.

12 12. Insurance Code Section 10169(d)(3) provides that “[t]he Department shall be the
13 final arbiter when there is a question as to whether an insured grievance is a disputed health
14 care service or a coverage decision.... If there appears to be any medical necessity issue, the
15 grievance shall be resolved pursuant to an independent medical review as provided under this
16 article.”

17
18 **BACKGROUND**

19 13. On four separate occasions, involving five members, between 2009 and 2011,
20 Respondent denied coverage for ABA therapy, asserting that ABA therapy was experimental
21 and/or investigational. The families appealed these denials through an Independent Medical
22 Review (IMR) process, and in every case the denial was reversed.

23
24 14. In each case, the doctors who conducted the independent medical reviews had
25 special qualifications in the area of autism, including child neurology, child psychology, and
26 pediatrics, and found that the prescribed ABA therapy was medically necessary. As required by
27 law, the Commissioner immediately adopted the IMR Decisions and promptly notified
28 Respondent, and requested that the medically necessary services be provided and paid for.

STATEMENT OF CHARGES

A. Improper Denial of Coverage on the Ground ABA Therapy Is “Experimental”

15. On four occasions between 2009 and 2011, Respondent denied coverage for ABA therapy on the grounds that ABA therapy was an experimental, investigational and unproven treatment, in violation of § 790.03(h)(1) and §10144.5(a).

16. Section 790.03(h)(1) prohibits insurers from misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverage contained in the contract. Respondent misrepresented a pertinent fact when it claimed that ABA therapy was an experimental, investigational and unproven treatment. Misrepresenting ABA therapy as experimental enabled Respondent to deny coverage for ABA therapy pursuant to its contract, which does not cover experimental treatments.

17. Respondent also violated §10144.5(a), California’s Mental Health Parity Act, which provides that insurance policies shall cover medically necessary treatment of severe mental illnesses under the same terms and conditions applied to other medical conditions; §10144.05(a) specifies that “pervasive developmental disorder or autism” is a “severe mental illness.” Pediatricians prescribed ABA therapy as medically necessary for the treatment of autism, which is a severe mental illness under the statute. Therefore, the Act requires that Respondent cover ABA therapy; Respondent nonetheless denied coverage in violation of §10144.5(a).

STATEMENT OF GROUNDS FOR MONETARY PENALTY AND POTENTIAL

LIABILITY PURSUANT TO INSURANCE CODE SECTIONS 790 *et seq*

18. The facts alleged above in Paragraphs 13 through 17 constitute grounds, under Section 790.05, for the Insurance Commissioner to order Respondent to cease and desist from engaging in such unfair acts or practices and to pay a civil penalty not to exceed five thousand dollars (\$5,000) for each act, or if the act or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each act as set forth under Section 790.035.

REQUEST FOR ORDER AND MONETARY PENALTY

1
2 WHEREFORE, Petitioner prays for judgment against Respondent as follows:

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

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

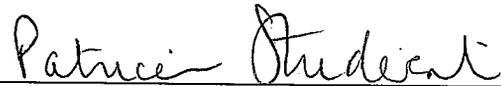
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10 3. Full restitution or reimbursement for acts or omissions in violation of the above-
11 cited provisions of law; and,

12 4. Costs incurred by the Department in bringing this action and any future costs to
13 the Department to ensure compliance.
14

15 CALIFORNIA DEPARTMENT OF INSURANCE

16 Dated: April 10, 2012

By



17
18 Patricia Sturdevant
19 Deputy Commissioner for Policy and Planning
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9 **OF THE STATE OF CALIFORNIA**
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11 In the Matter of
12 UNITEDHEALTHCARE INSURANCE
COMPANY,
13 Respondent.
14

File No. UPA-2012-00017

STIPULATION AND WAIVER

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

15
16 Respondent, UnitedHealthcare Insurance Company (“Respondent”), and the California
17 Department of Insurance (“Department”), stipulate as set forth herein:

18 1. Respondent holds a Certificate of Authority to transact the business of life and
19 disability insurance in the State of California, pursuant to § 700 *et seq.* of the California Insurance
20 Code.¹

21
22 2. Respondent is a Connecticut corporation.

23 3. Between 2009 and 2011, on four separate occasions, five of Respondent’s insureds who
24 had been diagnosed with or screened for pervasive developmental disorder or autism
25 (collectively, “autism”) made requests for coverage of Behavioral Health Treatment as defined in
26 California Insurance Code § 10144.51(c)(1), and in particular, for Applied Behavior Analysis
27

28

¹ Unless otherwise stated, all references are to the California Insurance Code.

1 therapy (“ABA therapy”). Respondent denied coverage for ABA therapy, asserting that ABA
2 therapy was experimental and/or investigational.

3 4. The families appealed these denials through an Independent Medical Review (IMR)
4 process, and in every case the denial was reversed. In each case, the doctors found that the
5 prescribed ABA therapy was neither experimental nor investigational and was medically
6 necessary. As required by law, the Commissioner immediately adopted the IMR Decisions and
7 notified Respondent. As a result of these IMR decisions, the Department ordered that
8 Respondent provide coverage for and pay for medically necessary ABA therapy for these
9 insureds.
10

11 5. The Department contends that coverage of medically necessary ABA therapy is
12 mandated by California Insurance Code § 10144.5 *et seq.*, the California Mental Health Parity
13 Act, without any limit other than medical necessity. The Department contends that ABA therapy
14 is the standard of care for autism and that delays in providing medically necessary ABA therapy
15 are unlawful and potentially catastrophic to the health of a patient.
16

17 6. The Department further contends that Respondent engaged in conduct in violation of
18 the California Mental Health Parity Act, § 10144.5, by failing to arrange and delaying in
19 arranging for provision of behavioral health treatment of pervasive developmental disorder or
20 autism for its insureds as required by §10144.5, and in so doing was acting in violation of § 790 *et*
21 *seq.*, by engaging in unfair or deceptive acts and in violation of § 790.03(h)(1) by misrepresenting
22 to claimants pertinent facts or insurance policy provisions relating to any coverage at issue.
23 Specific allegations are set forth in the Order to Show Cause and Statement of Charges; Notice of
24 Monetary Penalty; in the proceeding entitled In the Matter of the Certificate of Authority of
25 UnitedHealthcare Insurance Company, File No., UPA-2011-00017, served on March 10, 2012.
26
27
28

1 Among other things, the OSC seeks an Order requiring Respondent to provide coverage for ABA
2 therapy whenever medically necessary for all of its insured with autism.

3 7. Respondent denies the Department's allegations. Specifically, Respondent does not
4 believe it violated Cal. Ins. Code § 10144.5. Respondent further denies that it was in violation of
5 Cal. Ins. Code § 790.03 *et seq.*
6

7 8. Despite these denials, Respondent and the Department have discussed resolution of the
8 issues in this proceeding and now wish to resolve those issues, without the need for a hearing or
9 further administrative action, by Respondent agreeing to cover ABA therapy for all of its insureds
10 with autism, when medically necessary; and representing that it has sufficient provider network
11 capacity that enables it to do so, under the terms and conditions set forth herein. Respondent
12 further agrees that it will not reject any claims for medically necessary ABA therapy and will
13 continue to provide such medically necessary coverage to all of its insureds with autism through
14 June 30, 2012.
15

16 9. The parties mutually agree to enter into this Stipulation and Waiver and agree that the
17 resolution embodied in this Stipulation and Waiver is made in good faith. Therefore, by this
18 Stipulation and Waiver, Respondent waives any and all rights to a hearing in this matter, and any
19 and all other rights related to this proceeding which may be accorded pursuant to Chapter 5, Part
20 1, Division 3, Title 2 (commencing with § 11500) of the California Government Code and by the
21 California Insurance Code.
22

23 10. Respondent agrees to perform the obligations as stated in this Stipulation and Waiver.

24 11. This Stipulation and Waiver does not constitute an admission by Respondent of
25 liability, violation, wrongdoing or improper conduct.
26

COVERAGE FOR BEHAVIORAL HEALTH TREATMENT

27 12. Effective March 1, 2012 and continuing until July 1, 2012, Respondent agrees to
28

1 provide coverage for Behavioral Health Treatments, including ABA therapy, for its eligible
2 insureds who may have autism, consistent with California Insurance Code § 10144.51, and
3 further agrees that it has sufficient capacity and an adequate network or will enter into single case
4 agreements with geographically accessible providers, to enable it to provide coverage for such
5 treatment on the following terms and conditions:
6

7 (a) ABA therapy is ordered by and deemed medically necessary by a health care
8 provider(s) licensed under California law or by the state in which the ABA therapy is rendered,
9 under one of the following alternatives:

10 (1) If ABA therapy is rendered by a health care provider licensed under California
11 law or by the state in which the ABA therapy is rendered ("State - Licensed
12 Provider"), the State-Licensed Provider certifies that he or she personally provided
13 the services , and utilizes the billing codes supplied by Respondent; or
14

15 (2) If ABA therapy is rendered by individuals who are not State-Licensed
16 Providers but who maintain a BCBA-certification or who have ABA therapy
17 training and experience in serving children with autism, and the services are
18 overseen by a State-Licensed Provider either affiliated with the ABA therapy
19 provider or not affiliated with the ABA therapy provider, and has agreed to the
20 following:
21

22 (i) Bill for the ABA therapy utilizing the billing codes supplied by
23 Respondent

24 (ii) Maintain appropriate professional liability insurance covering the ABA
25 therapy provided;
26

27 ///

28 ///

1 (iii) Retain appropriate treatment records, including the identity of the individuals
2 providing the ABA therapy, in accordance with professional standards of practice;
3 and
4 (iv) Provide copies of the insured's ABA therapy records to Respondent on
5 reasonable request and at reasonable intervals.
6

7 (b) In the event that the insured's first-choice ABA therapy provider refuses to agree to
8 oversight by a state-licensed provider under these alternatives, Respondent is now and will
9 continue to locate providers who are known to Respondent and who will agree to the conditions
10 set forth in this Paragraph 11.

11 13. Until July 1, 2012, Respondent agrees to provide coverage for all medically necessary
12 ABA therapy for the treatment of autism for all current and future insureds in accordance with the
13 terms of this Agreement. The services shall be covered for a period equal to the length of time
14 specified by the insured's provider, or through June 30, 2012, whichever is shorter, at the number
15 of hours per week/month as specified by the insured's provider who ordered the ABA therapy.
16 Except for denials based upon the insured no longer being a covered insured or as otherwise
17 permitted by this Agreement and while this Agreement is in effect, any denial of coverage for
18 ABA therapy shall be construed as a denial based on medical necessity and will be subject to
19 review under the Department's Independent Medical Review process.
20
21

22 **CLAIMS PAYMENT AND REIMBURSEMENT**

23 14. All claims for payment to behavioral health treatment providers for authorized care
24 shall be paid timely and accurately in accordance with statutory requirements of the Insurance
25 Code and applicable regulations.

26 15. Respondent agrees to negotiate reasonable reimbursement rates and terms with
27 qualified autism service providers (as defined in California Insurance Code § 10144.51).
28

1 16. Claims for medically necessary Behavioral Health Treatment including ABA therapy
2 shall be adjudicated in the regular course without imposition of any unique or onerous conditions
3 on providers and complete claims shall be adjudicated and processed in accordance with the
4 provisions of the Insurance Code and applicable regulations.
5

6 17. Claims submitted by behavioral health treatment providers who have entered into a
7 contractual agreement with Respondent shall be reimbursed timely and accurately in accordance
8 with the terms of such contractual agreement and applicable statutes and regulations.

9 **BEHAVIORAL HEALTH TREATMENT PROVIDER NETWORK**

10 18. Respondent is currently working and will continue its efforts to establish a network of
11 ABA therapy providers, as defined in California Insurance Code §10144.51.
12

13 **CUSTOMER SERVICE OBLIGATIONS**

14 19. Respondent shall establish a dedicated customer service unit staffed by appropriately
15 trained individuals who will handle intake of questions or requests for verification of coverage or
16 eligibility, or prior authorization, if required, from Respondent's insureds seeking information
17 about their benefits for medically necessary behavioral health treatment or screening or diagnosis
18 of pervasive developmental disorder or autism.
19

20 **GENERAL PROVISIONS**

21 20. Respondent will make written changes in all of its relevant internal reference
22 materials, computer systems, provider manuals, instruction guides, coverage documents, medical
23 underwriting guidelines, medical management guidelines and similar materials to reflect the
24 changes in practices and policies consistent with the obligations stated in this Stipulation and
25 Waiver.

26 21. Respondent and the Department agree that this Stipulation and Waiver is intended to
27 be a complete and final resolution of the issues and allegations referenced in Paragraph 6 above
28

1 and that no further action will be brought against Respondent upon the matters referenced therein;
2 provided , however, that neither this Stipulation and Waiver nor the Order approving this
3 Stipulation and Waiver are in any way intended to limit or waive the Commissioner's authority to
4 bring disciplinary action against Respondent for alleged violations of California law arising from
5 improper denials of Behavioral Health Treatments occurring in the future or any other acts or
6 failures to act not referred to in Paragraphs 3 and 4. Similarly, nothing in this Stipulation and
7 Waiver shall be construed, in any way, as intent to limit Respondents right to challenge any
8 disciplinary or legal action.
9

10 22. Nothing contained in this Stipulation and Waiver or the Order approving this
11 Stipulation and Waiver shall prevent the Department from taking action to enforce this
12 Stipulation and Waiver or the Order approving this Stipulation and Waiver if Respondent is not in
13 compliance with the terms and conditions of this Stipulation and Waiver or the Order approving
14 this Stipulation and Waiver.
15

16 23. In the event that the parties agree, in writing, that an act of the California legislature or
17 the United States Congress, or applicable regulations issued by a federal agency, changes the law
18 governing the coverage of Behavioral Health Treatment, including ABA therapy, or other
19 provision of this Stipulation and Waiver, the law shall govern and no contrary provision shall be
20 binding on Respondent.
21

22 24. This Agreement shall have no force or effect after July 1, 2012.

23 25. Respondent represents and warrants that the persons executing this Stipulation and
24 Waiver on its behalf are authorized to enter into and execute this Stipulation and Waiver.

25 26. Respondent acknowledges that Cal. Ins. Code § 12921 requires the Insurance
26 Commissioner to approve the final settlement of this matter. Both the settlement terms and
27 conditions contained herein and the acceptance of those terms and conditions are contingent upon
28

1 the Commissioner's approval and Order.

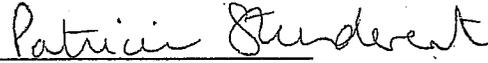
2 27. This Stipulation and Waiver is a compromise within the meaning of California
3 Evidence Code §§ 1152 and 1154.
4

5 Dated: April 10, 2012

UNITEDHEALTHCARE INSURANCE
COMPANY

7
8 Signed: 
9 Name: Payman Pezhman
10 Title: Deputy General Counsel

11 Dated: April ¹²10, 2012

CALIFORNIA DEPARTMENT OF INSURANCE
12 By 
13 Patricia Sturdevant
14 Deputy Commissioner for Policy and Planning
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