

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

Trenton N.,

Claimant,

vs.

Harbor Regional Center,

Service Agency.

OAH No. 2013040148

DECISION

Administrative Law Judge Jerry Smilowitz, State of California, Office of Administrative Hearings, heard this matter on July 18, 2013, in Torrance, California, at the offices of Harbor Regional Center (HRC or Service Agency).

Trenton N. (Claimant) was not present. He was represented by his mother.¹

Gigi Thompson, Manager Rights Assurance, represented the Service Agency.

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on July 18, 2013.

ISSUES

The parties agreed on the following statement of the issues to be decided: (1) Shall the Service Agency be required to pay the family's insurance deductible? (2) Shall the Service Agency be required to continue funding for in-home behavioral services for Claimant at the rate of four – six hours a week when the same services are authorized through the Claimant's private insurance, Anthem Blue Cross, but the family has chosen to not access them? As the hearing progressed, it developed that the second issue incorrectly characterized the actual issue presented by the parties and the evidence. Instead, the second

¹ Initials and titles are used to protect the privacy of Claimant and his family.

issue became the following: Shall the Service Agency be required to continue funding for in-home behavioral services for Claimant at the rate of four - six hours a week when the same services are authorized through the Claimant's private insurance, Anthem Blue Cross, but the family is financially unable to pay the deductible, and the Service Agency is prohibited by statute from paying the deductible on behalf of Claimant? This issue, and not the second one initially agreed upon by the parties at the commencement of the action, will be considered in this Decision.

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits 1-14; Claimant's exhibits A-B.

Testimony: For Service Agency, Lisa Simpson, a Program Manager with HRC; for Claimant, his mother and representative, and Faye Carter, Clinical Director for the Los Angeles offices of Support and Treatment for Autism and Related Disorders (STAR), a private program.

FACTUAL FINDINGS

1. Claimant is a seven-year old boy with a diagnosis of autism spectrum disorder who has been found eligible for regional center services. He lives at home with his parents and four siblings who range in age from five to seventeen years. Claimant attends an elementary school in his local school district, returning home in the afternoons for Applied Behavior Analysis (ABA) services at home. Initially, ten weekly hours of the ABA services were funded by the School District and six weekly hours by HRC. When Claimant started to attend school for a full day, the ABA home services provided by the School District were cut back to 5 hours a week.

2. The ABA services, alternatively identified as "Intensive Behavioral Intervention," have been provided by STAR, which describes its program in Claimant's Progress Report dated March 9, 2013, as being "individualized to provide optimal development for the child in an attempt to bridge developmental gaps. A prescription is made and the appropriate ABA interventions are chosen and goals are selected. The STAR program focuses on behavioral intervention, social skills instruction, language/communication skills, academic readiness skills, independent living skills, compliance training and parent education." As explained by Dr. Faye Carter, the Clinical Director of STAR, a key component of the approach is "modeling," where family members learn interventions they observe through hands-on applications.

3. In February of 2013, STAR reported that while Claimant continued to make incremental progress towards meeting his behavioral goals, particularly as shown in the decrease of self-stimulatory acts, he still engaged in scripting (the repetition many times over of a word or phrase, often first heard in some media outlet), which continues to be his most

major maladaptive behavior. Dr. Carter viewed Claimant as making a lot of across-the-board improvement. She gave an overall assessment that he would experience behavioral regression if services were stopped. Claimant's family is a good fit for ABA to be effective because most of the siblings are old enough to participate, while the younger one is now giving natural cues. In Dr. Carter's opinion, Claimant's family is one of the best in her program—"everyone is on the same page."

4. Claimant's parents are both physical therapists. His father works full time, averaging 55 hours a week, and his mother works part time—ten hours a week at a skilled nursing facility. They rely on each paycheck to meet their monthly financial needs. Last year, they were compelled to take out a loan of \$85,000 to settle a litigation claim. The parents pay \$13,000 a year for health insurance premiums, and are trying to deal with an outstanding lab bill of \$1500.

5. All of the members of the family have been insured through Anthem Blue Cross for the past 13 years in a single health insurance policy. The last change of the deductible was seven to eight years ago. Being unable to afford increasing premiums, they have chosen higher deductibles. This enables them to have insurance in the event of a catastrophic injury or illness. If such an occurrence were to happen, they hope that they would be able "to scrape together or borrow" the maximum out-of-pocket expenses that would be required to cover deductibles, copays, and coinsurance. There are seven members in the family, and each has an individual medical deductible of \$5900 per year along with a prescription drug deductible amount of \$875 each year. The Anthem Blue Cross policy provides that the first two insureds of an enrolled family to satisfy their deductibles in full will also satisfy the deductibles for the entire family. Even then, each member would be responsible for 30 percent of all services until he or she met the out-of-pocket maximum of \$8850, at which point Anthem Blue Cross would cover 100 percent. Office visit copayments are \$45 for each family member.

6. HRC initially agreed that it would fund payments to STAR in June of 2011 after the family's first few attempts to bill STAR's costs through Anthem Blue Cross were denied. HRC agreed to fund six hours of ABA per week on condition that Claimant reapplied to Anthem, provided HRC with copies of recent filed tax returns, and scheduled an Individual/Family Service Plan meeting at HRC.

7. The Individual/Family Service Plan (IFSP)² meeting was conducted on January 17, 2013. It concluded that scripting is the main behavior impeding Claimant's learning, and that he continued to have some deficits in the areas of peer interaction, adaptive living skills, independent play skill and behavior management. On the other hand, Claimant had progressed in showing caution when around things that are potentially dangerous, responding to commands while in the community, and lessening the intensity of his tantrum

² "Individual/Family Service Plan" is HRC's name for the interdisciplinary process identified as an Individual Program Plan (IPP) in the Lanterman Act.

behaviors. The IFSP provided for continued funding of services through the STAR program at the rate of six hours per week.

8. After the appeal process had resolved, STAR submitted several billings to Anthem Blue Cross. They were rejected because Claimant's individual deductible had not been met. Anthem Blue Cross would apply them only to reducing the deductible. Claimant's parents requested HRC to continue its funding of the STAR services due to their financial difficulty in meeting the yearly individual deductible in Claimant's health plan.

9. In a letter tantamount to a Notice of Proposed Action, HRC responded that it would, effective April 9, 2013, discontinue its funding of the STAR program services on the grounds that Claimant's family could access funding of the service through Anthem Blue Cross by meeting the yearly individual deductible and having STAR submit a request of a new authorization to begin on April 2, 2012 for continuation of services. HRC reasoned that the family was aware of the individual deductible that had to be met and decided when it purchased the insurance that it could meet the resulting level of financial impact on the family's budget.

10. Claimant's parents filed a timely appeal. His mother maintained at the hearing that they could not change plans at this time to have a lower deductible because doing so would result in a loss of grandfather status, causing premiums to significantly increase. She had spoken a great deal with Anthem Blue Cross representatives who told her that Claimant's condition would be deemed a pre-existing one. She considered taking Claimant off the family plan, but Anthem Blue Cross advised that he would be charged 300 percent more for the premium.

11. HRC acknowledged that, upon reviewing the tax returns submitted by the family, it determined that Claimant qualifies for copayment assistance consideration since his family's combined earnings are less than 400 percent of the federal poverty level. Although HRC did not expressly so state, presumably Claimant also qualifies for coinsurance payment assistance. Except for this acknowledgement, there was no evidence presented by HRC on whether Claimant's parents had the financial means to pay the deductible. The Exhibit List prepared by HRC identifies the Family Cost Participation Assessment Schedule, but it was neither attached to the list nor presented at the hearing.

12. While there are programs other than STAR which can teach the parents how to intervene when Claimant is engaging in maladaptive behavior, STAR is particularly well-suited to Claimant's needs. As HRC noted in a "Consumer Transaction" report dated December 13, 2012, of a meeting with STAR, "The greatest challenge that [mother], and the main reason she seeks supports of the therapist is that she has a very limited ability to change a strategies (*sic*) (to implement) when the strategy is no longer functional for the specific behavior. Parent is able to complete task analysis."

13. Claimant's mother also stated that new situations often arise with her son requiring a set of new skills for hands-on coping. She has to manage a large family with a

special needs child. The STAR approach enables her other children to learn how to interact with Claimant.

LEGAL CONCLUSIONS AND DISCUSSION

1. The Lanterman Act declares, “The State of California accepts a responsibility for persons with developmental disabilities and an obligation to them which it must discharge.” (Welf. & Inst. Code § 4501.)³ Towards this end, the Lanterman Act contemplates that “An array of services and supports should be established which is sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community.” (*Ibid.*) The statutory, regulatory, and contractual obligations for providing services are placed with regional centers. (*Ibid.*)

2. The type and amount of services and supports to a consumer are identified in IPP of that consumer. (§ 4646.5, subd. (a)(4).) The Legislature directs regional centers to “secure services and supports that meet the needs of the consumer, as determined in the consumer’s individual program plan. . . .” (§ 4648, subd. (a)(1).) As the California Supreme Court noted in *Association for Retarded Citizens-California v. Department of Developmental Services* (1985) 38 Cal.3d 384, 390, while regional centers have wide discretion in determining how to implement the IPP, they “have no discretion at all in determining *whether* to implement it; they must do so (§ 4648).” (Original emphasis).

3. Section 4659 provides that a regional center shall identify and pursue all possible sources of generic funding for regional center services. These sources include “Private entities, to the maximum extent they are liable for the cost of . . . insurance. . . .” Section 4659, subdivision (c), states that “Effective July 1, 2009, notwithstanding any other provision or law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from . . . private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage.”

4. For purposes of determining the array of generic funding sources which must be identified and pursued by a regional center, the question arose as to whether it applied to the parents of developmentally disabled minors. This was considered in an Opinion of the Attorney General. (73 Op.Atty.Gen., 156.) This Opinion examined, in part, section 4659, and concluded that regional centers may explore funding from parents. Nonetheless, as if in recognition that obtaining insurance can be an impossibly expensive proposition for many people, the Opinion notes that section 4659, subdivision (e) (then subdivision (c)), qualifies the extent to which a regional center can tap upon the resources of parents.

³ Unless expressly stated to the contrary, all statutory references are to the Welfare and Institutions Code.

5. Section 4659, subdivision (e) provides, “This section shall not be construed to impose any additional liability on the parents of children with developmental disabilities, . . . or deny services to, any individual who qualifies for regional center services but is unable to pay.” In other words, parents are a generic funding source, but only to the extent that they can afford to pay for the service.

6. Health and Safety Code section 1374.73, subdivision (a)(1), dictates that health care insurance plans providing hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for autism and related disorders.

7. Had the statutes described in Legal Conclusions 1 through 6 been the entire panoply of legislation that bears upon the issues in this matter, a palpable argument could have been made that, since Claimant’s parents are financially unable to pay the deductible in Claimant’s Anthem Blue Cross plan, and Anthem Blue Cross is statutorily required to provide coverage for the STAR program services Claimant is receiving, HRC is obligated to pay the deductible on behalf of Claimant. However, this argument is no longer available in light of the recent enactment of Section 4659.1. At subdivision (a), the statute allows a regional center to pay, in whole or in part, the applicable copayment or coinsurance required in the health insurance policy or health care service plan of the consumer’s parents for a service or support provided pursuant to the consumer’s IPP, but only when there is a demonstrable financial need. The possibility that a regional center may still authorize a copayment or coinsurance upon conducting a means-test does not extend to deductibles. Instead, subdivision (g) imposes a flat prohibition in stating, “Regional centers shall not pay health care service plan or health insurance policy deductibles.”

8. In light of section 4659.1, subdivision (g), and Legal Conclusion 6, the first issue is resolved against Claimant.

9. Claimant’s other argument is embodied in issue 2, as reformulated in this Decision. Since HRC is now statutorily prohibited from paying the deductible, can it be required to fund the STAR services directly? The reasoning is that section 4659.1 creates a conundrum in effectively preventing Claimant from obtaining a necessary service which his family cannot afford, even though section 4659, subdivision (e), excuses consumers from paying for insurance they cannot afford.

10. Section 4659.1 was introduced as a trailer bill—a proposed legislative act that makes necessary changes in State law to implement the provisions of the main budget bill. On its face, it was designed to provide assistance to consumers’ families by authorizing regional centers to cover insurance copayments and coinsurance when (1) such payments are necessary to ensure that the consumer receives the service or support, and (2) the family is financially unable to make these payments.

11. A common thread that runs throughout the Lanterman Act is the requirement that, in considering sources and service providers, a regional center must consider the cost-

effectiveness of each available option. In section 4512, subdivision (b), the Legislature directs regional centers, in considering which supports are necessary for each consumer, to make these determinations in the IPP process. The regional center must weigh a number of factors, including the needs of the consumer and his family, the effectiveness of each option, and the cost-effectiveness of each option.

12. Similarly section 4648, subdivision (a)(6)(d), directs consumers, their parents, and regional centers to determine the least costly provider of a service who is able to accomplish the consumer's IPP, consistent with the consumer and his family's particular needs, as identified in the IPP.

13. Health and Safety Code section 1374.73, subdivision (a)(1), requiring private health insurers to fund necessary ABA programs, has greatly expanded the available funding for ABA services. The legislation was sought to provide autistic individuals with highly-effective and well-proven approaches for controlling maladaptive behaviors. But in a largely unintended and unanticipated way, insurance policies, with their high deductibles, copayments, and coinsurance, now effectively prevent many consumers from accessing coverage for ABA programs which were funded by regional centers in the past.

14. As demonstrated by this case, the laudatory goal of Health and Safety Code section 1374.73 has, in some instances, worked to the disadvantage of these consumers. Instead of facilitating the consumer's ability to obtain ABA services, many, like Claimant's family here, stand to lose these services previously funded by regional centers because they are now expected to pay deductibles on existing policies originally purchased only for catastrophic events.

15. There is an obvious conflict. On the one hand, the Lanterman Act requires regional centers to identify a necessary service or program in an IPP and then do everything they can to promote cost-effectiveness by directing, when necessary, the consumer to access his or her parent's insurance coverage. Further, in recognition that a necessary service or program should be provided even when a consumer's parents lack the financial means to themselves fund a service, section 4659, subdivision (e), excuses those who are unable to pay. On the other hand, under section 4659.1, subdivision (g), a regional center may not pay for the deductible in a health insurance plan. Here, Anthem Blue Cross will accept only bills paid by Claimant's family as a reduction of the deductible, and will not pay STAR for its services until the deductible has been satisfied. As Dr. Carter stated, STAR cannot work for free. In effect, the new statute prevents Claimant from receiving services which have otherwise been identified in his IPP as integral for his development.

16. The legislative histories of sections 4743 (e) (inability to pay) and 4659.1, subdivision (g) (prohibition on regional centers paying for a consumer's insurance health care plan deductible) shed no light on resolving this issue. The deductible prohibition is unambiguous. Yet, under section 4659.1, a regional center may apply a means test to provide financial assistance to a consumer to meet the other two cost components of insurance coverage—copayments and coinsurance. Thus, the legislature has evinced an

intent to help consumers in paying for copayments and coinsurance, but prohibits a regional center from providing any assistance as to deductibles.

17. In determining legislative intent, courts have applied several approaches. One is to construe the words of the statute “in context, keeping in mind the statutory purpose, and statutes or statutory sections relating to the same subject must be harmonized, both internally and with each other, to the extent possible.” *Katz v. Los Gatos-Saratoga Joint Union High School Dist.* (2004) 117 Cal.App.4th 47, 54. A review of the Lanterman Act’s provisions strongly suggests two possible goals of the Act which are furthered by a prohibition of payment for a deductible by a regional center. The first is preserving the funds of the regional center system through requiring generic sources, including a family’s private insurance or health care service plan, to pay for necessary services. Secondly, section 4512, subdivision (b), when read in conjunction with section 4501, requires a regional center to provide only those specialized services and supports that are directed towards the alleviation of a developmental disability or are otherwise involved with a developmental disability, and not those conditions which are shared by all persons. The legislature likely concluded that, since a deductible can be satisfied through payments for general medical visits as well as the provision of services for a developmental disability, regional centers would be responsible for funding medical services outside of their statutory authorization. By contrast, a regional center would know whether a copayment or coinsurance is for non-specialized services, and would thereby be able to refuse payment, which is discretionary in the first place and payable only when there is some extraordinary event, catastrophic loss, or significant unreimbursed medical costs associated with the care of the consumer.

18. As applied to the facts presented here, the first goal—obtaining funding from other generic sources—is not furthered because the family is financially-strapped at this time, and cannot pay down the deductible. HRC determined that Claimant’s family did meet the legal requirements set forth in section 4659.1. The second goal also does not come into play since the STAR service program is specifically geared to Claimant’s condition, and has been proven to be an effective service for him.

19. There are two options in resolving this issue. The first is to decide that Claimant cannot receive a necessary service identified in his IPP because his parents are unable to pay for an insurance deductible that the regional center is now prohibited from covering. Significantly, in enacting the statutory prohibition on a regional center paying for the deductible, the legislature left intact the provision in section 4659, subdivision (e), which prohibits regional center coverage of services that are available through private insurance or a health care service plan, but otherwise exempts parents who are unable to pay. The second option is a decision that HRC continues its funding of the STAR program services until such time as it determines that the family has the financial ability to pay for the deductible. In the context of this case, this latter option more readily reconciles with the statutory purposes, mandates and requirements expressed in the Lanterman Act, and does not conflict with the evident legislative intent behind sections 4659, subdivision (e), and 4659.1.

ORDER

The appeal of Claimant's parents from a decision of HRC to decline funding of the deductible in their policy with Anthem Blue Cross is denied. Their appeal to require HRC to continue funding for four – six hours per week of ABA services through STAR is granted.

Dated: August 1, 2013



JERRY SMIDOWITZ
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter and both parties are bound by this Decision. Either party may appeal this Decision to a court of competent jurisdiction within 90 days.