

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

Claimant,

v.

NORTH LOS ANGELES COUNTY
REGIONAL CENTER,

Service Agency.

OAH No. 2013110214

DECISION

Carla L. Garrett, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on January 10, 2014, in Van Nuys, California.

Stella Dorian represented the North Los Angeles County Regional Center (NLACRC or Service Agency). Claimant was represented by his father (Father).

Oral and documentary evidence was received, and the record remained open to give Father an opportunity to submit additional documents by January 21, 2014, to support his claim that the Service Agency had established a precedent of paying Claimant's insurance deductible. The Service Agency was required to submit a response, if any, by January 28, 2014. Father timely submitted the following:

1. Cover letter dated January 17, 2014 from Father to ALJ Garrett, marked as Exhibit B;
2. Email dated February 4, 2013 from Father to Service Coordinator, Tsahi Banton, marked as Exhibit C;
3. Letter dated January 1, 2013 from Claimant's service provider, STAR of CA (STAR), marked as Exhibit D;
4. Billing statement dated January 13, 2014 from STAR, marked as Exhibit E;
5. Billing statement dated October 21, 2013 from STAR, marked as Exhibit F;
6. Billing statement dated March 12, 2013 from STAR, marked as Exhibit G;

7. Claim Details dated February 18, 2013 from Claimant's private insurance company, Anthem Blue Cross (Anthem), for the service dates of January 2, 2013 to January 15, 2013, marked as Exhibit H;
8. Claim Details dated March 5, 2013 from Anthem for the service dates of January 16, 2013 to January 30, 2013, marked as Exhibit I;
9. Claim Details dated March 5, 2013 from Anthem for the service date of January 31, 2013, marked as Exhibit J;
10. Billing statement dated March 28, 2013 from STAR, marked as Exhibit K; and
11. Claim Details dated March 25, 2013 from Anthem for the service dates of February 2, 2013 to February 14, 2013, marked as Exhibit L.

The Service Agency filed a timely response, marked as Exhibit 6, which was, in essence, a brief related to the merits of Claimant's case, and included a copy of an "Authorization to Purchase Services," dated April 5, 2013, marked as Exhibit 7, to support rebuttal testimony concerning Claimant's assertion that the Service Agency had set a precedent for paying his insurance deductible. The response did not state any objections to Claimant's documents. As such, Exhibits B, C, D, E, F, G, H, I, J, K, and L are admitted. In addition, Service Agency's Exhibit 6 is considered lodged, and Exhibit 7 is admitted. On January 28, 2014, the record was closed and this matter was submitted.

ISSUE

Must the Service Agency pay Claimant's private insurance deductible in order to ensure Claimant continues to receive behavioral therapy services from his private insurance carrier?

FINDINGS OF FACT

1. Claimant is six years-old, and is a consumer of the Service Agency. He has been diagnosed with autism, and requires behavior modification services. Claimant is eligible for services pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code, section 4500, et seq.¹

2. Initially, the Service Agency funded behavioral services for Claimant. However, in 2012, pursuant to Senate Bill 946, the Service Agency required Claimant's parents (Parents) to pursue behavior modification services for Claimant through their private insurance carrier, which they did. Parents advised that their insurance company, Anthem, required that they meet an \$8,200 deductible. The Service Agency continued to fund behavioral services for Claimant, paid directly to his provider, STAR, through February 2013, until the Service Agency received notice that Claimant's deductible had been met. The Service Agency paid STAR \$3,139.38 for behavioral services provided to Claimant in January 2013, and \$2,536.62 for services provided in February 2013, for a total of \$5,676. Anthem applied the Service Agency's payments to STAR to Parents' \$8,200 deductible. Thereafter, beginning in March 2013, Anthem began funding Claimant's behavioral services.

¹ All statutory references are to the Welfare and Institutions Code.

3. On September 27, 2013, the Service Agency informed Parents that new legislation, effective July 2013, prohibited the Service Agency from funding any future behavioral services for consumers who had private insurance that would provide such services. In addition, the Service Agency advised that it was prohibited from funding insurance deductibles. Parents informed the Service Agency that Anthem would require them to meet their \$8,200 deductible for 2014 before it would provide behavioral services for Claimant in 2014. Because Parents would not be able to pay Anthem \$8,200 at the commencement of 2014, they became concerned that Claimant would not be able to receive behavioral services for months, if at all. As such, Parents proposed that the Service Agency fund behavioral services until their deductible was met, like it had in January and February of 2013. The Service Agency declined, given the enactment of section 4659.1, which barred regional centers from funding health insurance deductibles.

4. On October 3, 2013, the Service Agency issued a Notice of Proposed Action and a letter to Parents advising that it had determined that, because Claimant had available private insurance to provide behavior services, it could not fund Claimant's behavior services. In addition, the letter stated, in essence, that despite the financial strain impacting Parents' ability to meet the \$8,200 deductible, the Service Agency was statutorily prohibited from paying health insurance policy deductibles. On October 15, 2013, Father filed a Fair Hearing Request on Claimant's behalf, and requested that the Service Agency pay Claimant's deductible.

5. At hearing, Father asserted that because the Service Agency had set a precedent for making payments toward the family's deductible, it should still be required to do so for 2014. Amy Gandin, Consumer Services Supervisor of the Service Agency, testified that at no time did the Service Agency intend for any payments it made to STAR to be considered deductible payments. The Service Agency simply paid for behavior modification services to STAR, because Claimant had a need for such services, and prepared an Authorization to Purchase Services form in that regard. Ms. Gandin explained that if Anthem considered the Service Agency's payments to STAR for January and February 2013 as payments toward Parents' deductible, that characterization was independent of the Service Agency.

LEGAL CONCLUSIONS

The Service Agency is neither required to fund behavioral therapy services nor pay Claimant's deductible, as discussed in more detail below:

1. In enacting the Lanterman Act, the Legislature accepted its responsibility to provide for the needs of developmentally disabled individuals and recognized that services and supports should be established to meet the needs and choices of each person with developmental disabilities. (§ 4501.) "Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with

developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. . . .” (*Id.*)

2. The Lanterman Act gives regional centers, such as Service Agency, a critical role in the coordination and delivery of services and supports for persons with disabilities. (§ 4620 et seq.) Thus, regional centers are responsible for developing and implementing individual program plans, for taking into account consumer needs and preferences, and for ensuring service cost-effectiveness. (§§ 4646, 4646.5, 4647, and 4648.)

3. Section 4512, subdivision (b), defines the services and supports that may be funded, and sets forth the process through which such are identified, namely, the Individual Program Plan (IPP) process, a collaborative process involving consumers and service agency representatives. Through this process, Claimant and Service Agency have determined that behavior modification services constitute necessary and appropriate services to address Claimant’s developmental needs.

4. At issue in this case is the manner in which the agreed-to services are to be funded. Section 4659, subdivisions (c) and (d), provides:

“(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children’s Services, 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. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer’s individual program plan (IPP), the prohibition shall take effect on October 1, 2009.

“(d) (1) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit. If, on July 1, 2009, a regional center is purchasing the service as part of a consumer’s IPP, this provision shall take effect on August 1, 2009. Regional centers may pay for medical or dental services during the following periods:

“(A) While coverage is being pursued, but before a denial is made.

“(B) Pending a final administrative decision on the administrative appeal if the family has provided to the regional center a verification that an administrative appeal is being pursued.

“(C) Until the commencement of services by Medi-Cal, private insurance, or a health care service plan.

“(2) When necessary, the consumer or family may receive assistance from the regional center, the Clients' Rights Advocate funded by the department, or area boards on developmental disabilities in pursuing these appeals.”

5. Recent legislation requires private insurers to provide coverage for behavioral health treatment for autism, including behavior modification services. Health and Safety Code section 1374.73, which was enacted pursuant to Senate Bill 946, provides, in pertinent part:

“(a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

“(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“(3) This section shall not affect services for which an individual eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

“(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

“(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health care service plan from selectively contracting with providers within these requirements. . . .”

6. As set forth in Legal Conclusion numbers 1, 2, and 3, the Lanterman Act guarantees certain services and supports to individuals with developmental disabilities, such as Claimant. These entitlements are recognized in Health and Safety Code section 1374.73, subdivision (a)(3), which provides that services for which a developmentally disabled consumer is eligible under the Lanterman Act shall not be affected by the private insurer's obligation to fund the services. It thus appears that the Legislature intended to shift the funding of autism services from taxpayers to insurers without impacting the entitlement to the services.

7. Effective July 27, 2013, Section 4659.1, subdivision (g), prohibited regional centers from paying health care service plan or health insurance policy deductibles.

8. Here, Claimant failed to meet his burden of demonstrating that the Service Agency must fund behavioral therapy services to help Claimant meet his deductible. The law expressly prohibits regional centers from funding behavioral therapy services when, as in this case, a consumer has private insurance which will cover those services. While Father believes that the Service Agency set a precedent for funding behavioral services for the purpose of helping Claimant meet his deductible, the evidence does not support this assertion. Specifically, documentary evidence, as well as the credible testimony of Ms. Gandin, established that the Service Agency simply funded behavioral services in 2013 in January and February, because Claimant required such services, and at no time did the Service Agency intend or consider its payments to STAR as deductible payments, irrespective of how Anthem classified those payments. Even if the Service Agency had paid Claimant's deductible in the past, the law, effective July 27, 2013, expressly prohibits regional centers from paying insurance deductibles from that point forward, as set forth in Legal Conclusion 7. Given these factors, Claimant's appeal must be denied.

ORDER

Claimant's appeal is denied.

Date: February 14, 2014



CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings

NOTICE

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