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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of BLUE SHIELD OF CALIFORNIA LIFE AND HEALTH INSURANCE CO., 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)**

ORDER TO SHOW CAUSE

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

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

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

of RESPONDENT would be in the public interest;

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

JURISDICTION AND PARTIES

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

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

STATUTES AND REGULATIONS

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

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

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

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

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

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

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

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

10. Insurance Code § 790.035 provides that "any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in § 790.03 is liable to the state for a civil penalty to be fixed by the Commissioner, 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. The Commissioner shall have the discretion to establish what constitutes an act."

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

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

12. Insurance Code § 10144.5, California's Mental Health Parity Act (hereafter "MHPA"), provides as follows:

> (a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions, as specified in subdivision (c).
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> (b) These benefits shall include the following:
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> (1) Outpatient services.
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> (2) Inpatient hospital services.
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> (3) Partial hospital services.
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> (4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

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

(1) Maximum lifetime benefits.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

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

(1) Schizophrenia.

(2) Schizoaffective disorder.

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

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

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

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

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

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

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

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

(3) begin any necessary investigation of the claim."

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

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

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

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

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

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

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

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

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

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

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

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

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

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BACKGROUND

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

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

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

23. In each case, doctors who conducted the independent medical reviews and who have special qualifications in the area of autism such as child neurology and clinical neurophysiology, found that the prescribed ABA therapy was medically necessary. As required by law, the Commissioner immediately adopted the IMR Decision and immediately notified 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 Not "Medically Necessary"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

55. Respondent denied coverage of BL's medically necessary ABA therapy and 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.

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

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

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

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

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

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

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

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

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

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

65. The facts alleged above in Paragraphs 20 through 64 constitute grounds, under CIC § 790.05, for the Insurance Commissioner to order Respondent to cease and desist from engaging in such 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 of the California Insurance Code

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

REQUEST FOR ORDER AND MONETARY PENALTY

WHEREFORE, Petitioner prays for judgment against Respondent as follows:

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

2. For acts in violation of Insurance Code Section 790.03 and the regulations promulgated pursuant to Section 790.10 of the Insurance Code, as set forth above, 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;

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

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