

STATE OF MICHIGAN  
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES  
Before the Director of Insurance and Financial Services

In the matter of:

██████████

Petitioner,

v

File No. 153586-001

Blue Cross Blue Shield of Michigan,

Respondent.

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Issued and entered  
this 26<sup>th</sup> day of July 2016  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

██████████ (Petitioner) had surgery. She disputes the decision of her health insurer, Blue Cross Blue Shield of Michigan Mutual Insurance Company (BCBSM), to apply the allowed amount for that surgery (and related professional services) to her annual deductible.

On June 29, 2016, the Petitioner filed a request with the Director of Insurance and Financial Services for an external review of BCBSM's decision under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Director accepted the request on July 7, 2016.

The Petitioner receives health care benefits through an individual plan that is underwritten by BCBSM. The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. BCBSM responded on July 14, 2016.

The issue in this external review can be decided by a contractual analysis. The Director reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

**II. FACTUAL BACKGROUND**

The Petitioner's health care benefits are defined in by the terms of the *Blue Cross Premier Bronze Extra Benefits Certificate* (the certificate).

On April 8, 2015, the Petitioner had surgery on her right knee and received related professional services from various in-network providers. BCBSM covered all these services but applied a total of \$3,677.04 to the Petitioner's unmet annual deductible for network services, which she must pay out of pocket.

The Petitioner appealed the cost-share requirement through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated June 10, 2016 affirming its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

### III. ISSUE

Did BCBSM correctly apply cost sharing to the Petitioner's April 8, 2015 surgery?

### IV. ANALYSIS

#### BCBSM's Position

In its final adverse determination, BCBSM's grievance coordinator told the Petitioner:

... [D]uring your [*grievance*] Conference, you explained that while you included these invoices and that while you are generally confused about the cost-share requirements of your 2015 plans, you are specifically appealing the deductible applied to the surgical services provided on April 8, 2015. As a Grievance and Appeals Coordinator, I reviewed those claims, your appeal, and your benefits with BCBSM. I confirmed we applied the deductible correctly. You remain liable for the amounts of \$1,936.50, \$167.78, \$1,321.10, and \$251.66.

You were covered under the *Blue Cross Premier Bronze Extra Benefits Certificate* ... from January 1, 2015 to May 1, 2015, which has separate cost-share requirements for in-network and out-of-network providers. For the purposes of the following descriptions concerning cost-share, I will describe the requirements for in-network providers. After which, I will detail specific cost share for your April 8 services.

There are four basic elements of cost-share: deductible, coinsurance, copayments, and out-of-pocket maximums. **Section 7: Definitions** (Page 157) of the *Certificate* defines deductible as the "amount that you must pay for covered services, under any certificate, before benefits are payable." This means that until the deductible amount was met, you were responsible for the costs of covered services. **Section 2: What You Must Pay** (Pages 12 and 13) of the *Certificate* explains you had a \$6,000 deductible for services provided by in-network providers.

**Sections 2: What You Must Pay** (Page 16) explains that your yearly maximum out-of-pocket for in-network providers was \$6,600. These out-of-pocket expenses are comprised of all in-network deductibles, coinsurance and copayments for covered medical and prescription drug services. Once the out-of-pocket maximum was met, no more deductible, coinsurance, or copayments were required for the remainder of the calendar year. Costs related to non-covered services are not applied to this maximum.

Because you had not met your \$6,600 [sic] in-network deductible requirement at the time your April 8, 2015 claims were processed, the full amounts approved for the services were applied to your deductible. As a result, you remain liable for those deductible amounts.

\* \* \*

During your Managerial-Level Conference, you expressed that you were never told how the deductible works during your enrollment and that you felt your deductible was too high for the Premier Bronze coverage. I reviewed the recording of your November 25, 2014 enrollment phone call. During that call, you asked several questions about the premium, deductible, and copayment requirements and the Health Plan Advisor (HPA) provided you with that information. Moreover, during the call you explained to the HPA your priority when choosing coverage was a lower premium. After discussing the premium, the cost-share, and the benefits associated with the Premier Bronze plan, you elected to enroll in that plan.

### Petitioner's Position

In her external review request, the Petitioner wrote:

My former employer no longer covered or provided health insurance for any duty disability, retiree's under the age of 62. According to the ACA law you must have healthcare coverage or suffer a fine. I went through the marketplace and BCBSM to find the best coverage for me that would be affordable on my monthly pension. Michigan's premiums are so high it took me several different calls to attempt to keep cost low. I was in three different BCBSM insurance programs. But the monthly premiums were extremely expensive. On April 8, 2015, I was told I would need surgery on my right knee and was not aware the expense of surgery, therapy would be so high.

### Director's Review

In a review, under the Patients Right to Independent Review Act the Director can only determine if BCBSM correctly processed the claims for the Petitioner's surgery under the term and conditions of her certificate.

The *Blue Cross Premier Bronze Extra Benefits Certificate* is clear that there is a \$6,000.00 calendar year deductible requirement for in-network services that must be met before most benefits are payable.<sup>1</sup>

At the time of her April 8, 2015 services, the Petitioner had not met that deductible.<sup>2</sup> Therefore, BCBSM applied its full approved amount of \$3,677.04 to the unmet \$6,000.00 deductible. As a result, the Director concludes and finds that BCBSM correctly processed the claims related to the Petitioner's surgery.

#### V. ORDER

The Director upholds BCBSM's final adverse determination dated June 10, 2016.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the Michigan county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin,  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director

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1. Preventive care, primary care office visits, up to four specialist office visits, and generic prescription drugs are not subject to the deductible (certificate, p. 12).  
2. See the May 1, 2015, explanation of benefit payments statement.