

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. 154438-001

Health Alliance Plan of Michigan
Respondent

Issued and entered
this 19th day of July 2016
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On July 5, 2016, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner receives group health care benefits from the Health Alliance Plan of Michigan (HAP), a health maintenance organization. The plan is sponsored by the Ford Motor Company. The Director notified HAP of the request and asked for the information it used to make its final adverse determination. HAP submitted the information on July 12, 2016. After a preliminary review of the material submitted, the Director accepted the Petitioner's request on July 12, 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 HAP's *HMO Subscriber Contract* as amended by *Rider 301 Health Engagement Program*. *Rider 301* established a program called "Aspire" that "rewards healthy lifestyle choices" by offering lower cost sharing requirements to subscribers who adopt certain healthy living

practices. Such HMO-based programs are authorized by Michigan law. See section 3517 of the Michigan Insurance Code, MCL 500.3517.

On January 1, 2011, the Petitioner was enrolled in the Aspire program. In order to continue to receive enhanced benefits in 2016, the Petitioner was required to complete three steps by March 31, 2016:

- have his physician complete the member qualification form (MQF);
- obtain a score of at least 80 points on the MQF; and
- complete the online health risk assessment (HRA).

The Petitioner's physician completed the MQF but, according to HAP, the Petitioner did not submit his completed HRA by the March 31, 2016, deadline. As a result, HAP placed him in the standard benefits plan, with higher out-of-pocket expenses, effective April 1, 2016.

The Petitioner appealed HAP's decision through its internal grievance process. At the conclusion of the grievance process, HAP issued a final adverse determination dated June 8, 2016, upholding its decision. The Petitioner now seeks the Director's review of that final adverse determination.

III. ISSUE

Did HAP correctly place the Petitioner into the standard benefits level of his benefit plan?

IV. ANALYSIS

Petitioner's Argument

In a June 28, 2016 letter submitted with his external review request, the Petitioner wrote:

I am appealing to have my ENHANCED PLAN coverage reinstated from this point forward. Part of HAP program is the insurer goes online into the HAP website to complete a questionnaire each year. As in the past years, I did this process again this year too from home early in the open enrollment period. (The form was completed 2nd time 4/28/16, but from my office this time when I learned they did not have my submission). I am not computer savvy; only use it with difficulty ...

* * *

Being penalized financially (to date \$865 for doctor visits at the higher rate) because I don't have a newer computer and that I don't use the internet for this private information is unfair.

Respondent's Argument

In its final adverse determination, HAP wrote:

We upheld the denial of your request because you did not complete the online Health Assessment (HA) by the required deadline. In order to qualify for the Enhanced Plan, you must complete the HA and Member Qualification Form (MQF) by the program deadline. You completed your HA on April 28, 2016. Your qualification period was from October 1, 2015 to March 31, 2016. The following mailings were sent from HAP that explained the Health Engagement requirements and deadline dates: a Welcome Kit, sent December 28, 2015, Ford Reminder Letter #1 sent February 1, 2016, Ford Reminder Letter #2 sent February 26, 2016, Ford Reminder Letter #3 sent March 24, 2016, and a Transfer to Standard Plan Letter sent April 22, 2016.

Regretfully, we are unable to transfer you into HAP's Enhanced Benefit Plan because you did not meet the Health Engagement Plan requirements by the end of the qualification period. Therefore, any costs incurred for medical services associated with your benefit change to the Standard Plan, will remain your financial responsibility.

Please know that you will have the opportunity to re-qualify for the Enhanced benefit plan for the 2017 benefit year.

Director's Review

Rider 301 explains what HAP members must do to retain enhanced benefits in subsequent enrollment years:

Eligible Members who have qualified to earn Enhanced Benefits in their preceding year may continue to earn Enhanced Benefits by following the steps outlined in "How to Earn the Health Engagement Program Enhanced Benefits in the First Year of Enrollment" in Section A. These steps will begin on the date of renewal of each year of the enrollment.

One of the steps is to complete the Health Risk Assessment (HRA) within 90 days of enrollment (i.e., by March 31, 2016). There is no exception in the rider to that requirement.

The Petitioner asserts that he completed the required form early in the re-enrollment process. He also states that he is not computer savvy and experienced difficulty when trying to submit the form and notes HAP should have an option of mailing in the required questionnaire. Under the Patient's Right to Independent Review Act, the Director's role is limited to determining whether HAP properly administered health care benefits according to the terms and provisions of the applicable coverage documents, in this case the *Subscriber Contract* and *Rider 301*. The Director has no authority to amend a benefit program's requirements because of the difficulty an individual may have in complying with the requirements.

The Director finds that HAP's decision to place the Petitioner in standard benefits after March 31, 2016, was consistent with the terms of the health engagement program rider.

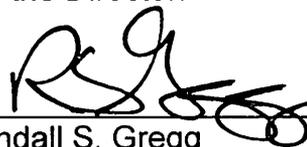
V. ORDER

The Director upholds Health Alliance Plan of Michigan's June 8, 2016 final adverse determination.

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 Director of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin
Director

For the Director:



Randall S. Gregg
Special Deputy Director