

STATE OF MICHIGAN
DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v

File No. 102724-001

Humana Insurance Company
Respondent

Issued and entered
this 12th day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On January 29, 2009, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the information received the Commissioner accepted the request on February 3, 2009.

The Commissioner notified Humana Insurance Company (Humana) of the external review and requested the information used in making its adverse determination. The company provided its information on February 9, 2009.

The issue in this matter can be determined by analyzing the Humana certificate of insurance (the certificate), the contract that defines the Petitioner's health care coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II FACTUAL BACKGROUND

The Petitioner is covered by Humana under an underwritten large group health plan. From May to December 2008, the Petitioner had psychotherapy visits with XXXXX, MD. Dr. XXXXX is not a Humana network provider. Humana applied the covered charges for the visits to the Petitioner's non-network deductible and coinsurance, leaving the Petitioner responsible for an out-of-pocket expense of \$2,019.60 for the first 20 visits in 2008 and entirely responsible for any additional visits in 2008.

The Petitioner appealed Humana's decision and exhausted Humana's internal grievance process. Humana maintained its denial and sent a final adverse determination dated December 30, 2008.

III ISSUE

Did Humana correctly process the Petitioner's claim for psychotherapy visits?

IV ANALYSIS

Petitioner's Argument

The Petitioner has an eating disorder (anorexia nervosa). From May 2008 through December 20, 2008, she received psychotherapy for this condition from Dr. XXXXX. Humana covered the first 20 visits but applied the entire maximum allowed amount for those visits (\$2,019.60) to the non-network deductible. After the Petitioner had exhausted her 20 outpatient mental health visits for 2008, she had to pay all additional charges herself. None of those additional charges were applied to the non-network deductible.

The Petitioner says she has a \$3,000.00 non-network deductible but Humana will not let her reach that amount because it will not credit any payments after the first 20 visits. She says "they

have never paid a dime” for her mental health treatment.

The Petitioner also believes the newly-enacted (2008) federal mental health parity law prohibits Humana from applying different deductibles, visit limits, etc., to mental health services than it does for other illnesses and sickness, and to treat mental illness like any other medical illness. The Petitioner wants Humana to cover additional outpatient therapy visits beyond the maximum of 20 allowed in its certificate.

Humana Insurance Company's Argument

Humana explained its position in its final adverse determination:

This decision was based on your Benefit Plan Document which states outpatient care and office therapy individual and group sessions for mental health services are limited to a maximum of 20 visits per year. Please see the enclosed Benefit Plan Document, Schedule of Benefits – Behavioral Health, page 25 that was utilized in making this determination.

* * *

[Y]ou are correct that the Federal Mental Health Parity Act states that mental health treatment should be paid for like any other treatment. The provider who you are seeking services from is a nonparticipating provider, therefore the claims process to your nonparticipating level of benefits just like any other treatment. The Act doe[s] not affect conditions relating to the amount, duration or scope of mental health benefits. This includes, but is not limited to, the number of allowed visits.

The certificate says that “outpatient care and office therapy individual and group sessions for mental health services are limited to a maximum of 20 visits per year” (page 25) Humana said the Petitioner reached her maximum of 20 visits for outpatient office mental health therapy for 2008 with the October 11, 2008, visit. By that time, a total of \$2,019.60 was applied to the \$3,000.00 non-network deductible. Since the \$3,000.00 non-network deductible had not been met, Humana was not obligated to cover 70% of the payable benefit for non-network mental health services.

Humana believes that it correctly processed the Petitioner’s mental health therapy claims.

Commissioner's Review

The Petitioner does not believe it is fair that she has exhausted her outpatient mental health therapy benefit and yet Humana has not paid anything for her treatment.

Humana provided coverage at the non-network level because the provider was not in its network. Before non-network benefits are payable, the Petitioner must satisfy a \$3,000.00 deductible. That deductible is not solely for mental health services; other non-network care can also apply. Once the \$3,000.00 deductible is met, Humana pays 70% of covered charges thereafter. However, in the Petitioner's case, her outpatient mental health benefit was limited to 20 visits per calendar year and she reached that limit before she met her deductible.

Further, not all of the provider's charge was applied to the deductible. The provider charged \$150.00 per visit, but Humana's maximum allowed amount for the service was only \$100.98 so only that amount was applied to the deductible. The certificate also says (page 4): "You are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable *deductible*, *coinsurance* and/or *copayment*. Any amount you pay to the provider in excess of your *coinsurance* or *copayment* will not apply to your *out-of-pocket limit* or *deductible*."

The Petitioner decided to use a non-network provider. Had she used a network psychotherapist, she would have reached the network deductible of \$1,500.00 before she exhausted her 20 visit limit and some of the therapy charges would have been covered 100%.

The Petitioner also argued that Humana's determination of her claims is not consistent with the federal mental health parity law. However, the Commissioner notes that the law was not in effect at the time the Petitioner received her outpatient mental health services and therefore cannot be considered in this review.

Based on the facts presented here, the Commissioner finds that Humana correctly applied the terms and conditions of the Petitioner's certificate and state law.

V ORDER

The Commissioner upholds Humana Insurance Company's final adverse determination of December 30, 2008. Humana's application of the non-network deductible and rejection of coverage for visits beyond the 20 allowed per year was consistent with the terms of the contract.

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 sixty days from the date of this Order in the circuit court for the 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 Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.