

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

File No. 102793-001

v

US Health and Life Insurance Company
Respondent

Issued and entered
this 30th day of March 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 2, 2009, Robert Demers (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 material submitted the Commissioner accepted the request on February 9, 2009.

The Commissioner notified US Health and Life Insurance Company (USHL) of the external review and requested the information used in making its adverse determination. The company provided its information on February 5, 2009.

The issue in this matter can be determined by analyzing 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 a retired City of Detroit police officer. He receives health care benefits under a USHL certificate of group insurance (the certificate). The certificate provides benefits for both network and out-of-network services. Out-of-network services come with higher out-of-pocket costs for the Petitioner.

On April 18, 2008, the Petitioner was taken by ground ambulance from Henry Ford Health System's Brownstown facility to the Henry Ford Hospital in Detroit. XXXXX (XXXXX) provided the transport. XXXXX is an out-of-network provider and so USHL covered the ambulance service claim at the out-of-network level.

The Petitioner appealed, asking USHL to provide coverage at the network level. USHL reviewed the claim but upheld its payment amount. The Petitioner exhausted USHL's internal grievance process and received its final adverse determination letter dated December 29, 2008.

III ISSUE

Did USHL properly deny coverage at the network level?

IV ANALYSIS

Petitioner's Argument

On April 18, 2007, the Petitioner drove himself to the Henry Ford Brownstown facility after experiencing chest pains and shortness of breath. He underwent a CAT scan that revealed a possible aortic aneurysm in the abdominal area. His attending physician advised him that his condition could not be treated at the Brownstown facility and that he needed to be transferred to Henry Ford Hospital in Detroit.

The Petitioner said he and his wife wanted to drive to the Detroit hospital but the physician indicated that if the aneurysm ruptured while en route, death could be imminent without immediate treatment. Understanding the severity of his prognosis, he followed his

physician's advice and was transported by ambulance.

The Petitioner argues that coverage should be provided at the network level because it was an emergency situation and, according to his physician, an ambulance was required. The Petitioner asks that the transport be re-billed to reflect an emergency (XXXXX billed it as non-emergency). Further, he believes XXXXX's charge was "way of line" if it is under contract with Henry Ford Health System and the charges should be reconsidered.

Respondent's Argument

In its December 29, 2008, final adverse determination letter, USHL said:

According to the schedule of benefits out of network ambulance services is subject to a \$425.00 deductible and payable at 70 percent of usual and customary amount. * * * The payment of the claim was paid appropriately according to the schedule of benefits.

USHL further explained its decision in its February 3, 2009, response to the Office of Financial and Insurance Regulation:

Whether there was an emergency or not does not enter into the claim processing for this bill. The question is whether the ambulance provider was in-network or out-of-network, not whether there was an emergency.

* * *

The group insurance coverage provides certain benefits when the employees and dependents receive services from network providers and certain other benefits when they receive services from providers that are not in the network. The benefit amounts payable are based on the network status of the providers. Benefits are not based on the effort of the employees in attempting to obtain services from network providers or on the reasons they do not, such as an emergency. The insured is not required to use the services of any one particular provider. There is no special handling for out-of-network emergencies.

* * *

USHL processed this claim correctly as an out-of-network claim at the out-of-network coinsurance percentage of 70%. XXXXX billed \$1,269.50. USHL determined that \$379.30 was over the usual and customary amount, leaving a balance of \$890.20. USHL paid \$623.14. [The Petitioner] is responsible for 30% of \$890.20 which is \$267.06 plus the amount over usual and customary of \$379.30 if XXXXX chooses to bill him for it. [Underlining in original]

Since XXXXX is not a network provider, USHL says it processed the claim for his services at the non-network level according to the terms of the certificate.

Commissioner's Analysis

The certificate's "Schedule of Benefits" describes coverage as follows:

	IN-NETWORK	OUT- OF- NETWORK
Deductible	\$175 per person \$350 per family	\$425 per person \$850 per family
Annual Coinsurance maximum (does not include Deductible or Copays)	\$825 per person \$1650 per family	\$1575 per person \$3150 per family
Copay (Does not apply to Coinsurance maximum)	Per Service. Amount as indicated.	

	IN-NETWORK (after Deductible unless waived)	OUT-OF-NETWORK (after Deductible)
Ambulance Services	100% of eligible expenses	70% of eligible expenses

As the schedule shows, ambulance services from an out-of-network provider is subject to the non-network deductible (not applied in this case) and then is covered at 70% of the eligible expense. In this case, USHL determined that the usual and customary (or eligible) expense for the ambulance service was \$890.20.

There is no dispute that XXXXX is an out-of-network provider. Therefore, USHL paid 70% of the \$890.20 eligible expense or \$623.14, leaving Petitioner responsible for the 30% coinsurance amount (\$267.06) plus the amount above the usual and customary amount (\$379.30).

Given the seriousness of the Petitioner's condition at the time, it is understandable that he would not be primarily concerned about whether the ambulance service was in USHL's network. Nevertheless, USHL's coverage is based solely on the network status of the provider. Network level benefits are only available when services are received from network providers. The certificate does not cover any out-of-network care at the network level, even in an emergency or even if there are no network providers available.

The Commissioner finds that USHL correctly covered the Petitioner's ambulance transport with XXXXX under the terms of the certificate.

**V
ORDER**

The Commissioner upholds US Health and Life Insurance Company's December 29, 2008, final adverse determination in the Petitioner's case.

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.