

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. 104041-001

v

US Health and Life Insurance Company
Respondent

Issued and entered
this 15th day of June 2009
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On April 4, 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.* The Commissioner reviewed the information submitted and accepted the request on April 10, 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 information on April 16, 2009.

The issue here can be decided by an analysis of the terms of the certificate of group Insurance (the certificate), the contract that defines the Petitioner's health care benefits. The Commissioner 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

This case involves ambulance services provided to the Petitioner under the Petitioner's health care coverage with USHL.

On January 2, 2009, Petitioner, who has multiple sclerosis, had a seizure. Her husband called 911 and requested an ambulance to take Petitioner to the hospital. The XXXXX emergency medical service ambulance transported Petitioner to XXXXX.

The ambulance service was not in USHL's network of providers so the claim was processed as an out-of-network benefit subject to a deductible and coinsurance. The Petitioner appealed through USHL's internal grievance process. USHL reviewed the claim but upheld its decision and issued a final adverse determination dated March 30, 2009.

III ISSUE

Did USHL correctly process the claim for ambulance service?

IV ANALYSIS

Petitioner's Argument

The Petitioner's husband wants USHL to cover the cost of the ambulance service as though it were an in-network benefit. He says the ambulance was summoned in an emergency situation and there was no opportunity to look for a network ambulance service. Under the circumstances, he believes USHL should process the claim as an in-network service.

Respondent's Argument

USHL stated in its final adverse determination:

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

USHL explained its decision in a letter to the Office of Financial and Insurance Regulation dated April 16, 2009:

The [Petitioner's] 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 insured is not required to use the services of any one particular provider. 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. There is no special handling for out-of-network emergencies.

In-network and out-of-network benefits are different because of the discounts US Health and Life receives when an insured person receives treatment from a network provider. These discounts are not available from out-of-network providers. Benefits are based on whether a provider is in the network and provides a discount or is out-of-network. Benefits are not based on the availability of providers. [Underlining in original]

USHL believes it processed the claim for the ambulance service according to the terms of the certificate.

Commissioner's Review

The ambulance service charged \$745.00 to transport the Petitioner to the hospital. USHL's allowed amount for the service (i.e., the eligible amount) was \$560.27. Under the terms of the certificate, the out-of-network ambulance service is subject to a \$425.00 individual out-of-network deductible and then USHL pays 70% of the balance of the allowed amount.

As shown in the table below, the Petitioner was left responsible for \$527.81 of the ambulance charge:

	Item	Amount	Petitioner's Responsibility
A	Ambulance Charge	\$ 745.00	
B	Ineligible Amount	(\$ 184.73)	\$ 184.73
C	USHL's Allowed Amount (A – B)	\$ 560.27	
D	Deductible Applied *	(\$ 250.00)	\$ 250.00
E	Balance (C – D)	\$ 310.27	
F	USHL's Responsibility (70% of E)	\$ 217.19	
G	Petitioner's Responsibility (30% of E)	\$ 93.08	\$ 93.08
	Total		\$ 527.81

* Petitioner's certificate has a \$425.00 deductible for out-of-network services. At the time of this claim, Petitioner had \$250.00 remaining to be paid in order to meet the deductible requirement.

The Commissioner finds that USHL correctly processed the claim for out-of-network

ambulance services according to the terms of the certificate.

The Petitioner's husband believes the ambulance service should be treated as an in-network benefit because he never had any real opportunity to arrange for service from a network ambulance provider under emergency conditions. While Petitioner's situation was serious and left no time to search for an in-network ambulance service, there is nothing in the certificate or in state law requiring USHL to handle a claim for services from an out-of-network ambulance provider as an in-network service. It is the network status of the provider that determines how the claim will be processed. In this case the ambulance provider was not a member of USHL's network and so USHL, following the terms of the certificate, processed the claim as an out-of-network benefit.

The Commissioner finds that USHL correctly processed the ambulance service claim under the terms of the certificate.

**V
ORDER**

The Commissioner upholds USHL's adverse determination of March 30, 2009.

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.