

**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. 110711-001

v

Blue Cross Blue Shield of Michigan  
Respondent

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Issued and entered  
this 5<sup>th</sup> day of January 2011  
by Ken Ross  
Commissioner

**ORDER**

I  
**PROCEDURAL BACKGROUND**

On March 11, 2010, XXXXX, authorized representative of his wife 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 request and accepted it on March 18, 2010.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 5, 2010.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Flexible Blue II Individual Market Certificate* (the certificate). *Rider Flexible Blue 2 –D 2500/5000* (the rider), also applies. 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

On December 7, 2009, the Petitioner requested a mail order prescription from Medco for the drug Abilify. The charge for this prescription was \$3,210.31. BCBSM applied the total amount toward her deductible.

The Petitioner appealed BCBSM's handling of her claim. BCBSM held a managerial-level conference on February 17, 2010, and issued its final adverse determination dated February 23, 2010.

## III ISSUE

Did BCBSM correctly process the Petitioner's claim for the drug Abilify?

## IV ANALYSIS

### Petitioner's Argument

The Petitioner states that on October 1, 2009, she and her husband became members of BCBSM. On December 4, 2009, her prescription for the drug Abilify needed to be refilled. She used the Medco mail service to fill the prescription. She had used Medco for this drug prior to having BCBSM and the cost to her was \$200.00.

Within a week, Medco called the Petitioner and indicated that she needed to contact BCBSM and provide updated billing information. While speaking to BCBSM the Petitioner's husband asked what the copayment would be for the prescription. He was informed that the copayment would be no more than \$200.00.

On December 14, 2009, the Petitioner received her Abilify refill from Medco which indicated that she was responsible for the drug's entire cost of \$3,210.31. BCBSM indicated that this amount was applied to their deductible. The Petitioner argues that she was given incorrect information from BCBSM and was never told about any deductible requirement. Because she was misled, she believes that BCBSM should be required to pay for her prescription with only a \$200.00 copayment.

BCBSM's Argument

BCBSM says that Petitioner's certificate includes the rider which increased the annual deductible for all covered services provided by panel and nonpanel providers. The rider provides for the following deductibles:

**Deductible Requirements**

\* \* \*

Panel Providers

- \$2,500 for a one-person contract
- \$5,000 for a family contract (two or more members)

Non-Panel Providers

- \$5,000 for a one-person contract
- \$10,000 for a family contract (two or more members)

BCBSM says that based on these deductibles the Petitioner was required to satisfy a \$5,000 deductible when using a panel provider for prescription drugs. Since she had not satisfied her deductible prior to this, the \$3,210.13 cost of her Abilify prescription was applied toward the \$5,000 deductible.

The Petitioner indicated that her husband was informed by BCBSM in a telephone conversation that they were only responsible for a copayment and there was no mention of a deductible. After researching the customer service telephone worksheets, BCBSM did not find any remarks made to the Petitioner indicating that they did not have to pay a required deductible. The only questions asked were about how much the copayment would be. There was no question about the deductible.

BCBSM believes that it applied the appropriate deductible and did not mislead the Petitioner about her benefits.

Commissioner's Review

The BCBSM *Flexible Blue Group Benefit Certificate*, as amended by the rider, increased the annual deductible for all covered services, requiring a \$5,000 deductible each calendar year.

The Petitioner states that BCBSM advised her husband that her copayment for Abilify prescription would be no more than \$200.00. This appears to be accurate. However, the Petitioner

also contends that BCBSM misled her when it failed to inform her in telephone calls that she also had a \$5,000.00 deductible. BCBSM does not believe that it misinformed the Petitioner.

The Commissioner cannot resolve the factual dispute about whether or not BCBSM misinformed the Petitioner. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether BCBSM properly administered health care benefits under the terms and conditions of the applicable insurance certificate, related riders, and relevant state law. Resolution of factual disputes such as the one described by the Petitioner cannot be part of a PRIRA review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The language of the certificate and rider are clear the Petitioner must satisfy the \$5,000.00 deductible before BCBSM is required to provide coverage for her Abilify or any other covered services.

The Commissioner finds that BCBSM processed the claims in compliance with the certificate and rider.

## **V ORDER**

BCBSM's final adverse determination of February 23, 2010, is upheld. BCBSM is not required to provide any reimbursement for the Abilify provided on December 7, 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.