

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

File No. 116844-001

v

Health Alliance Plan of Michigan
Respondent

Issued and entered
this 28th day of April 2011
by R. Kevin Clinton
Commissioner

ORDER

I
BACKGROUND

On September 2, 2010, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation (OFIR) for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

Health Alliance Plan of Michigan (HAP) was notified of the request for external review and on September 10, 2010, furnished the information it used to make its final adverse determination. After a preliminary review of the material submitted the Commissioner accepted the request.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner is a member of HAP. His health care benefits are defined in HAP's HMO Subscriber Contract (the contract) and Rider 308, "Health Engagement Program" (the rider), which adds a wellness program to his coverage. The Health Engagement Program promotes and rewards good health by offering "enhanced benefits" (lower copayments, coinsurance, and deductibles) if certain conditions are met. Members who do not adopt or maintain healthier behaviors receive "standard benefits."

On January 1, 2009, Petitioner and his family were initially enrolled in the Health Engagement Program with enhanced benefits. For the benefit year beginning April 1, 2010, the Petitioner was required to re-enroll in the program by completing a member qualification form (MQF) and an online health risk assessment (HRA).

The Petitioner did not complete his HRA by the March 31, 2010, deadline. In addition, his spouse did not complete her MQF by the deadline. As a result, HAP terminated Petitioner's enrollment with enhanced benefits and he and his family were placed in the standard benefits level, which has higher out-of-pocket expenses.

The Petitioner appealed his removal from enhanced benefits through HAP's internal grievance process and received its final determination letter dated July 8, 2010.

III ISSUE

Did HAP properly deny the Petitioner continued coverage in the Health Engagement Program with enhanced benefits?

IV ANALYSIS

Petitioner's Argument

The Petitioner believes HAP shares some of the blame for his failure to meet the requirements to keep enhanced benefits. He told HAP in an April 23, 2010, letter:

I have called your Client Services phone number (888-819-240) on April 23, 2010 and explained that I did indeed go to the web-site and did take what I remember to be a survey and had a custom health plan put together for me. The Client Services does not have any record of this.

I have asked to retake the HRA, and have been denied. I feel that this decision is incorrect. Sometimes, there are technical reasons why the records may not be accurate. I know that I did go to the web-site and did attempt to follow all directions.

There should be a feed-back mechanism that lets you know if the HRA has not been successfully administered.

The Petitioner also explained in a September 16, 2010, letter submitted for his external review:

At the end of the year, HAP does not erase the records. So when you sign up again next year, their database is already populated with data. This makes it difficult to determine what is required to be updated.

I have been working with HAP to get this resolved...however they have not been able to see a single point I have made. My insurance premiums paid to them must be around \$8,000 per year, I am amazed that they would jeopardize losing a customer over such small monetary issues.

The Petitioner acknowledges that his spouse did not submit her MQF on time, but says that HAP only discovered it after he filed his grievance. Additionally, the Petitioner acknowledges that he completed another assessment on March 29, 2010, and says he was not aware that he completed the wrong assessment until the enrollment period ended.

The Petitioner wants enhanced benefits restored effective April 1, 2010.

Respondent's Argument

In its July 8, 2010, final adverse determination, HAP explained the decision for not enrolling the Petitioner into the HAP Enhanced Benefits program from April 1 through December 31, 2010, in part:

The rider outlines the requirements for retaining enhanced benefits:

Health Engagement Program Eligible Member or Eligible Member is the Subscriber and an eligible adult family member who is either the spouse or domestic partner of the Subscriber and who is enrolled for health care coverage with HAP through this Program.

A. HOW TO EARN THE HEALTH ENGAGEMENT PROGRAM ENHANCED BENEFITS

Members with Enhanced will begin the plan year with Enhanced Benefits for the first 90 days. Members with Standard Benefits will begin the plan year with Standard Benefits for the first 90 days. To continue receiving, or to begin receiving, the Enhanced Benefits for an additional 90 days or the second quarter of the plan year, each Eligible Member must take the following steps:

1. During the qualification period, each Eligible Member must complete the following two activities to qualify for Enhanced Benefits for the next 90 days:
 - a. Complete an online Health Risk Assessment (HRA)
 - b. Meet with the Eligible Member's PCP to complete a MQF which will assess the Eligible Member's medical condition and/or lifestyle behavior for the following areas:
 - Blood pressure
 - Smoking
 - Cholesterol
 - Blood sugar
 - Weight
 - Alcohol use
 - Preventive health screenings

* * *

B. HOW TO EARN THE HEALTH ENGAGEMENT PROGRAM ENHANCED BENEFITS IN SUBSEQUENT YEARS OF ENROLLMENT

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

* * *

C. STANDARD BENEFITS OPTION

1. If an Eligible Member chooses not to complete the HRA and MQF according to program requirements, the Eligible Member and enrolled HAP dependents will automatically receive Standard Benefits after the initial 90 days of coverage.
2. If an Eligible Member does not qualify for Enhanced Benefits, the Eligible Member and enrolled Dependents will receive Standard Benefits.

HAP says it mailed reminder letters about the program's requirements to the Petitioner on January 26 and February 23, 2010. HAP says it transferred Petitioner and his spouse to the standard benefit level because they failed to meet the program's requirements by the March 31, 2010 deadline.

Commissioner's Review

Health maintenance organizations like HAP are permitted to offer wellness programs like the Health Engagement Program that provide a financial incentive for members to improve and maintain their health. See MCL 500.3426. As a condition of remaining in the Health Engagement Program with enhanced benefits, a member must meet requirements specified in the rider.

Continued receipt of enhanced benefits was contingent upon the submission of the MQF forms by March 31, 2010. Although the Petitioner offered an explanation for why he did not fulfill the requirements, there was nothing in the record that would lead to the conclusion that HAP unreasonably prevented him from completing the requirements.

The Commissioner concludes that the terms of the rider were not met and therefore the Petitioner did not qualify for continued participation in the HAP Health Engagement Program at the enhanced level from April 1 through December 31, 2010.

V ORDER

The Commissioner upholds HAP's July 8, 2010, final adverse determination. HAP is not required to return the Petitioner and his family to the Enhanced Benefits plan effective April 1, 2010.

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.

R. Kevin Clinton
Commissioner