

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. 117802-001

v

Aetna Life Insurance Company
Respondent

Issued and entered
this 30PPth day of June 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On October 29, 2010, 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 notified Aetna Life Insurance Company (Aetna) of the external review and asked for the information it used in making its adverse determination. The information was received on November 4, 2010. The Commissioner reviewed the information and accepted the Petitioner's request on November 8, 2010.

The Petitioner receives group health care coverage from Aetna under a PPO plan. Her benefits are defined in a booklet-certificate (the certificate) that includes a rider with the schedule of benefits. The issue here can be decided by an analysis of that certificate. 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

The Petitioner had an outpatient procedure¹ on June 25, 2010, at a network hospital. When Aetna processed the claim for the surgery, it applied a portion of the allowed amount to the Petitioner's network deductible before making its payment. Aetna denied the Petitioner's request to waive the deductible.

The Petitioner appealed Aetna's handling of the claim through its internal grievance process. Aetna upheld its original determination and sent the Petitioner its final adverse determination dated September 1, 2010.

III. ISSUE

Did Aetna correctly apply a deductible to Petitioner's outpatient surgery?

IV. ANALYSIS

Petitioner's Argument

In her request for external review Petitioner explained:

On June 8, 2010, I contacted Aetna regarding out of pocket expense for a procedure. Provided procedure codes and they stated my total out of pocket would be \$400 - \$500. Never mentioned that I would be responsible for my deductible! This has put my family in a financial hardship and would have sought an alternate treatment!

The Petitioner believes that Aetna should waive the deductible because she was not told about it when she inquired about the out-of-pocket cost of the surgery.

Respondent's Argument

In its September 1, 2010, final adverse determination Aetna advised the Petitioner:

The Committee reviewed your Summary Plan Description and your plan specifically states that the benefit for in-network benefits [*sic*] has a \$2,500.00 deductible per calendar year and you need to satisfy any applicable deductible before the plan will begin to pay benefits. According to our records, the documentation showing that you contacted Aetna on June 8, 2010 indicates that you were informed there is a \$2,500 in-network deductible and outpatient surgery is 80% after deductible. Since the Committee must adhere to the terms of your contract, your request to waive the deductible has been denied. The claim for [surgery] on June 25, 2010

¹ Hysteroscopy, CPT code 58563.

was processed correctly according to your plan benefit. Aetna contends its determination of the Petitioner's claim was in compliance with the terms of the certificate.

Commissioner's Review

The Petitioner's certificate clearly states there is a calendar year individual deductible of \$2,500.00 for network services that must be met before any benefits will be paid by Aetna. The certificate explains the network deductible (rider, p. 18):

Network Calendar Year Deductible

This is an amount of network covered expenses incurred each Calendar Year for which no benefits will be paid. The network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

After the deductible is satisfied, the schedule of benefits (rider, p. 12) says that network outpatient surgery is paid at 80%. The Commissioner reviewed the material submitted and concludes that Aetna processed the Petitioner's claim for outpatient surgery in accord with the terms and conditions of the certificate.

Aetna's allowed amount for the surgery was \$4,538.67. Since the Petitioner had satisfied only a portion of her \$2,500.00 individual network deductible² at the time of the surgery, \$2,045.78 was applied to the deductible, leaving a balance of \$2,492.89 ($\$4,538.67 - \$2,045.78 = \$2,492.89$). Aetna then paid 80% of that balance or \$1,994.32. The Petitioner's out-of-pocket cost for the surgery was \$2,544.35 (the \$2,045.78 deductible, plus \$498.57 coinsurance).

The Petitioner argues that she should not have to pay the deductible because Aetna representatives did not inform her about it. She is requesting the Commissioner to order Aetna to waive the deductible. She indicates that she would have sought other treatment if she had known about the deductible.

Nevertheless, the Commissioner cannot order the result the Petitioner seeks. Aetna disputes the Petitioner's contention (it states she was told about the deductible when she called on

June 8, 2010) and the Patient's Right to Independent Review Act (PRIRA) does not provide a way for the Commissioner to resolve such disputes. PRIRA offers only a "paper hearing"³ and does not have a process to make fact findings based on oral evidence. Moreover, under PRIRA, the Commissioner's role is limited to determining whether Aetna correctly applied the terms and conditions of the Petitioner's coverage. The Commissioner, like other administrative agencies, lacks the authority to order relief based on theories such as misrepresentation or reliance.

The Commissioner notes that individual network deductible is explained or mentioned in several places in the certificate, including in the schedule of benefits (rider, p. 12) where it states that network outpatient surgery is payable at 80% "after Calendar Year deductible."

The Commissioner concludes and finds that Aetna correctly processed the Petitioner's claims for her outpatient surgery.

V. ORDER

The Commissioner upholds Aetna's September 1, 2010, final adverse determination. Aetna correctly processed the claims for the Petitioner's June 25, 2010 outpatient surgery.

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 60 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

² There is also a \$5,000.00 family deductible but it also had not been met at the time the Petitioner had her surgery.

³ See *English v Blue Cross Blue Shield of Michigan*, 263 Mich App 449 (2004).