

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

In the matter of

XXXXX

Petitioner

File No. 120481-001

v

Humana Insurance Company
Respondent

Issued and entered
this 19th day of July 2011
by R. Kevin Clinton
Commissioner

ORDER

I. Procedural Background

On April 7, 2011, XXXXX, on behalf of her minor son 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 Petitioner receives health care benefits under a policy issued by Humana Insurance Company. The Commissioner notified Humana of the external review and requested the information it used to make its adverse determination. The Commissioner received Humana's response on April 8, 2011. On April 14, 2011, after a preliminary review of the information received, the Commissioner accepted the Petitioner's request for external review.

The issue here can be decided by applying the terms of policy. 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

Petitioner and his family reside in XXXXX, Texas. On January 15, 2011 Petitioner injured his head. A band-aid was placed on the injury and he was taken to XXXXX Medical Center emergency room. He was not admitted to the hospital and was discharged later the same day.

The medical center charged \$757.50; the treating physician charged \$368.00. Humana's allowed amount for this care totaled \$686.13. Humana applied the policy's \$100.00 emergency room copayment and then applied the remainder of its allowed amount of \$586.13 to Petitioner's deductible. The medical center and treating physician now look to the Petitioner for payment of the \$586.13.

Petitioner appealed Humana's claim calculations through Humana's internal grievance process. Humana affirmed its decision in a final adverse determination dated February 24, 2011.

III. Issue

Did Humana correctly process Petitioner's claim for the January 15, 2011 emergency room visit?

IV. Analysis

Petitioner's Argument

The Petitioner's mother believes the emergency room deductible should be waived because her son was not treated by anyone while he was in the emergency room. In her appeal to Humana, the Petitioner's mother wrote:

. . . We paid the copay of \$100 and now we are receiving bill of \$580 from Hospital which is not fair. I am feeling so bad but I want to let you know that the Doctor never did anything and even the injury was not cleaned up. They even kept a Band Aid on the injury which never costs even 10 cents and left [it] like that. W[e] asked several times and requested them to dress the injury as he is a 4 year old kid and there might be many chances that he might hit something again if it is not dressed as it is his head part.

Today they did send bill for \$580 which is not acceptable and how can we pay as we are paying Humana every month expecting that you will help us in these situations.

Please take my request as i [would] have not approached you if they have done some stitches to injury or some scanning. But with out even dressing or cleaning up the injury they are sending us the bill.

Respondent's Argument

In its February 24, 2011, final adverse determination, Humana declined to waive the deductible:

According to the Benefit Plan Document, emergency room services are first subject to the network deductible and a \$100.00 copayment per visit. On page 19 of the Benefit Plan Document, it states:

Hospital emergency room services

<i>Network hospital</i>	100% benefit payable after <i>network provider deductible</i> and \$100 <i>copayment</i> per visit. Copayment waived if admitted.
<i>Non-network hospital</i>	100% benefit payable after <i>network provider deductible</i> and \$100 <i>copayment</i> per visit. Copayment waived if admitted.

At the time the claim was processed, the network deductible was not met. Therefore, \$468.13¹ was applied to the network deductible and the \$100.00 copayment was applied. You are financially responsible for \$568.13.

Humana contends its handling of the Petitioner’s claims complied with the terms of the policy.

Commissioner’s Review

The Petitioner’s health care plan requires both deductibles and copayments for health care services, including emergency room care. The Petitioner acknowledges that she is obligated to pay a \$100.00 copayment for her son’s emergency room care. However, she would like Humana to waive the deductible.

Petitioner’s annual deductible is \$2,000.00 per individual and \$4,000.00 per family (assuming Humana’s network providers are used). The Petitioner had not met the annual deductible requirements of the policy at the time her son was treated in the emergency room. The policy’s deductible requirements are detailed on pages 10-11:

An annual *deductible* is a specified dollar amount that *you* must pay for *covered expenses per year* before most benefits will be paid under the *policy*. There are individual and family *network provider* and *non-network provider deductibles*. The *deductible* amount(s) for each *covered person* and each covered family are as follows [table omitted], and must be satisfied each *year*, either individually or combined as a covered family. Once the family *deductible* is met, any remaining *deductible* for a *covered person* in the family will be waived for that *year*.
Copayments do not apply toward the annual *deductible*.

¹ This is the deductible for the hospital charge and does not include the additional \$118.00 deductible associated with the emergency room physician’s charge which was billed separately.

Any expense incurred by *you* for *covered expenses* provided by a *network provider* will be applied to the *network provider deductible*. Any expense incurred by *you* for *covered expenses* provided by a *non-network provider* will be applied to the *non-network provider deductible*. (Italics in original)

Petitioner's mother asserts that Petitioner was never treated for his injury and, therefore, only the \$100.00 copayment should apply in this case.

Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law. The Commissioner finds that Humana properly applied the deductible and copayments under the terms of the policy.

V. Order

The Commissioner upholds Humana's final adverse determination of February 24, 2011. Humana is not required to waive the network deductible required by the policy.

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