

STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES
Before the Director of Insurance and Financial Services

In the matter of:

████████████████████,

Petitioner,

v

File No. 144883-001

Alliance Health and Life Insurance Company,

Respondent.

Issued and entered
this 14th day of January 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On December 8, 2014, ██████████ (Petitioner) filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Petitioner received health care benefits through the ██████████ ██████████ Four Star Health Program (the program). The program was underwritten by Alliance Health and Life Insurance Company (AHL). The Director immediately notified AHL of the external review request and asked for the information it used to make its final adverse determination. AHL provided its response and, after a preliminary review of the material submitted, the Director accepted the request on December 15, 2014.

The issue here can be decided by a contractual analysis. The Director 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's health care benefits were defined in the program's "benefit document" and schedules. The program's benefit year runs from April 1 to March 31.

From January 11 to March 8, 2013 the Petitioner received outpatient services from [REDACTED]. The charge for the services was \$6,335.66. AHL denied coverage, saying the charges exceeded the program's annual maximum for outpatient services.

The Petitioner appealed the denial through AHL's internal grievance process. At the conclusion of that process, AHL issued a final adverse determination dated September 6, 2014, affirming its original decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did AHL correctly deny coverage for the Petitioner's outpatient services?

IV. ANALYSIS

AHL's Argument

In its final adverse determination, AHL explained its decision to the Petitioner:

Upon receipt of the Second Level Appeal submitted, your case was re-evaluated by the HAP Grievance Committee. You informed the committee of the many issues you have experienced. Additionally, you explained your situation that you were not aware of an outpatient maximum. [REDACTED] [REDACTED] Four Star Health Plan provides a basic level of coverage using an Exclusive Provider Organization (EPO) plan. This means the plan selected by you had a \$3,500 per person annual maximum for outpatient services. The reason for this basic plan design is to ensure that the monthly premium is affordable for both employers and employees. **Therefore, based on all the information presented in the case, we are unable to cover the amount that you have requested.**

Petitioner's Argument

In an undated attachment submitted with the external review form, the Petitioner wrote:

. . . I feel I was misled in regards to how this matter was handled. Before each procedure, I questioned the secretaries at each facility to make sure I was covered. When speaking to my doctor about going through with said procedures, I questioned further, just to make sure. Time and time again, I was assured that the matter would be handled internally and they would notify me beforehand when a procedure was not to be covered. What I find most vexing about this is that I did my part to ask the right questions and I was misled by the [REDACTED] professionals. I am even more frustrated by this because [REDACTED] owns [REDACTED], which leaves me wondering how such an egregious communication error could

occur. I am also wondering why, now after 14 months, this is the first I am hearing of this balance. I did not even receive an EOB. In closing, I feel taken advantage of and misled because I did my part to make sure I was covered and it seems as though neither [REDACTED] nor [REDACTED] want to take responsibility for this. I feel that billing me 14 months later is wrong and suspicious.

In her grievance statement to AHL, the Petitioner further explained her position:

Between the months of January and March 2013, I had several procedures done that I thought were covered. I was merely following the recommendations of my doctor and because I received no documentation from [REDACTED] about approaching my cap, I went ahead with the procedures. I received absolutely no documents or notifications at all, not even an explanation of benefits. Now, after over 14 months have passed; I am bombarded with a \$6335.66 bill that I am unable to pay because I had no idea that I wasn't going to be covered. If I had [been] notified at any point before the procedures I would have reconsidered my options or prepared my finances to cope with this tremendous burden. I have the right to be notified of my impending loss of coverage and to be billed in a timely manner. It is unreasonable to expect payment after so much time has passed without a single piece of correspondence. At this point, I feel as though I am being held responsible, when the issue lies with poor communication between [REDACTED] and the [REDACTED].

Director's Review

The program's "Schedule of Medical Coverage" says there is a \$3,500.00 annual maximum for outpatient services. AHL provided a chart of the Petitioner's claims for the benefit year running from April 1, 2012 to March 31, 2013. The chart shows that the Petitioner reached the \$3,500.00 maximum for outpatient services by January 11, 2013. Therefore, the Director concludes that AHL was correct when it no longer covered outpatient services after that date.

The Petitioner says she was not aware of the annual maximum for outpatient services, that neither AHL nor the [REDACTED] advised her that she was near or had exceeded the annual maximum until she had accumulated large bills for service. However, under the Patient's Right to Independent Review Act, the Director can only determine if AHL properly administered the health care benefits under the terms and conditions of the program's benefit documents. The Director does not have the authority to alter the terms of coverage because an enrollee was not aware of the program limits.

In this case, the Director concludes that AHL correctly applied the terms of the benefit documents when it only covered outpatient services up to the limit of \$3,500.00.

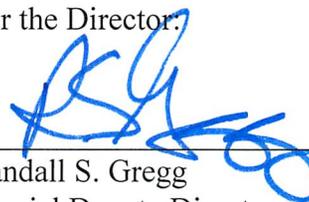
V. ORDER

The Director upholds Alliance Health and Life Insurance Company's September 6, 2014, final adverse determination.

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 Michigan 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 Director of Financial and Insurance Regulation, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood
Director

For the Director:



Randall S. Gregg
Special Deputy Director