

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. 144063-001

Blue Cross Blue Shield of Michigan

Respondent

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

**ORDER**

**I. PROCEDURAL BACKGROUND**

On December 19, 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.* After a preliminary review of the material submitted, the Director accepted the request on December 30, 2014.

The Petitioner has health care coverage through an individual plan that is underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director immediately notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on January 5, 2015. The Petitioner, through his attorney, provided additional information on January 8, 2014.

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

**II. FACTUAL BACKGROUND**

Up until December 31, 2013, the Petitioner and his wife were covered by a BCBSM plan that did not comply with new requirements of the federal Patient Protection and Affordable Care Act (PPACA) and BCBSM discontinued it.

On January 1, 2014, the Petitioner's coverage changed and he became insured under an individual plan whose benefits are defined in BCBSM's *Keep Fit and Member Edge Individual*

*Market Certificate.*<sup>1</sup> The certificate is amended by *Rider OV-5 Office Visit Benefits* and *Rider IOC \$5,000 / \$10,000-I, \$8,500 / \$17,000-O, \$8,500 / \$17,000 OOPM Inpatient and Outpatient Cost-Sharing Requirements.*

Between June 20 and July 17, 2014, the Petitioner had various medical services.<sup>2</sup> BCBSM's approved amount for these services was \$8,255.83. BCBSM applied \$7,962.10 to the inpatient and outpatient deductibles, applied \$80.00 in office visit copayments, applied \$20.88 in coinsurance, and then paid the providers \$192.85. This left the Petitioner responsible out-of-pocket for \$8,062.98.

The Petitioner appealed BCBSM's claims processing decisions through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated October 23, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ANALYSIS

In a September 19, 2014, letter filed with the external review request, the Petitioner explained his complaint:

I have been with [BCBSM] since May 1, 2009. The plan that I had was Value Blue Traditional. I had signed up for this with an agent over the phone. The premium I was paying was \$526.90 per month. My deductible was \$1,000 per individual or \$2000 per family. The maximum out of pocket was \$4500.

On December 30, 2013 I was apparently switched to a new policy without my consent since I did not sign up for this. [BCBSM] signed me up to this new program. The program for my wife and I was \$603.80 per month. Our out of pocket cost per person is \$17,000.

As I understand it, the whole purpose of the Affordable Care Act was to provide affordable health insurance. When the average family makes \$40,000 a year, I can't see how a premium of \$603.80 per month along with a deductible of \$17,000 is affordable. When one adds premiums of \$7,236 per year plus \$17,000 per year deductible, the health insurance costs \$24,236 per year. Frankly, I feel this is criminal.

I pay my premiums and have been loyal to [BCBSM] and they do this to me. In medical bills, I owe a balance of \$7553.39 to Flower Hospital and \$537.74 to Toledo Hospital. Note, Blue Cross paid nothing to Flower and \$8288 to Toledo. They let both hospitals write some off (they paid Flower nothing). I have already paid over \$4500. Each day more bills keep coming. Under my former insurance I would have paid a maximum of \$4500. I don't understand how they can write off

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<sup>1</sup> At the time the services in question were performed, the certificate was BCBSM form no. 351D, approved 05/14.

<sup>2</sup> The Petitioner had other services during 2014 but these were the services identified in BCBSM's final adverse determination as the subject of the internal grievance.

everything to a hospital and I get stuck owing the bill. I feel I should pay \$4500 maximum out-of-pocket-no more, no less.

It is the Petitioner's contention that BCBSM signed him up for coverage under the *Keep Fit and Member Edge Individual Market Certificate* without his consent. BCBSM explained in its final adverse determination how the Petitioner came to be covered under the *Keep Fit* plan:

We acknowledge that you would prefer to keep your previous Value Blue Traditional plan. However, this plan was discontinued because it did not meet the health care reform requirements for a Qualified Health Plan. BCBSM enrolled you in the *Keep Fit and Member Edge Individual Market Certificate* (Keep Fit) to avoid a gap in coverage.

\* \* \*

BCBSM decided to move forward with our process of discontinuing non-compliant health plans and transitioning our members and new customers into health plans that meet all the requirements of the Affordable Care Act. We are choosing to move forward into the future because we believe our decision is the responsible thing to do, and are trying to act responsibly toward our members who are impacted the most.

As we discussed during the [grievance] conference, BCBSM mailed multiple letters to the address on file advising you the Value Blue Traditional plan did not meet all of the requirements of the health care reform law and would be discontinued on December 31, 2013. In addition, we encouraged you to contact us to review your coverage options. To ensure you had continuous coverage with Blue Cross, we transitioned you into our Keep Fit product. To accept this option, you were required to pay the initial premium by the due date on the bill sent in mid-December.

I reviewed our telephone records and confirmed [your wife] called the customer service center and made a payment by telephone on December 23, 2013. The representative advised her that coverage under the current plan would be canceled effective December 31, 2013 and the payment would be applied to the Keep Fit plan. . . .

In its final adverse determination, BCBSM's representative also explained how it processed the claims:

I have considered all of the facts and information provided in your appeal; however, after review of your health care plan, I confirmed the processing of each claim is correct. Therefore, additional payment is not available. In-network diagnostic services, diagnostic radiology- professional component (reading), inpatient medical care, and laboratory services are subject to an in-network deductible. In-network inpatient medical care is also subject to 30 percent coinsurance after the deductible is met. In-network office visits are subject to a flat-copayment requirement.

\* \* \*

I understand that you have been with BCBSM for many years and that you are upset with the member cost-sharing requirements under the Keep Fit plan; however, we must process claims and administer benefits subject to the terms and conditions of your coverage.

The Director also reviewed the claims for the services between June 20 and July 17, 2014, and concludes that they were correctly processed under the terms and conditions of the *Keep Fit and Member Edge Individual Market Certificate* and its riders.

The Petitioner does not really dispute that conclusion. His complaint is that he was signed up, without his consent, to a plan that had much higher cost sharing requirements compared to his prior plan. BCBSM, on the other hand, has offered a justification for how and why the coverage changed.

In any event, a review under the Patient's Right to Independent Review Act cannot address that issue; under the act, the Director can only determine if an insurer correctly administered health care benefits according to the terms of the applicable insurance contract and any relevant state law. In this case, the Director finds that BCBSM did.

#### IV. ORDER

The Director upholds BCBSM's final adverse determination of October 23, 2014.

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 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood  
Director

For the Director:



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Randall S. Gregg  
Special Deputy Director