

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

In the matter of:

██████████
Petitioner

v

Blue Cross Blue Shield of Michigan
Respondent

File No. 144963-001

Issued and entered
this 16th day of March 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On February 19, 2015, ██████████ authorized representative of his 21 year-old son ██████████ (Petitioner), filed a request for an expedited external review with the Director of Insurance and Financial Services. The request for review concerned insurance coverage for medical treatment the Petitioner received over an eight month period in 2014.¹

On February 25, 2015, after a preliminary review of the information submitted, the Director accepted the case for review. (The case did not qualify for an expedited review because the medical services at issue had been completed by the time the request for review was filed.)

The Petitioner receives health care benefits under an individual plan underwritten by BCBSM with an effective date of January 1, 2014. The plan provides coverage for the Petitioner and his mother. The plan's benefits are defined in BCBSM's *Blue Cross Premium Gold Benefits Certificate*. The Director 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 March 4, 2015.

1. An earlier version of the request for review was filed in November 2014. However, the request was not complete and, for that reason, was resubmitted on February 19, 2015.

This case presents an issue of contractual interpretation. 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

From February 9, 2014 to October 15, 2014, the Petitioner received various medical services. The providers submitted to BCBSM bills totaling \$635,439.61. BCBSM provided coverage until it determined, in August 2014, that the Petitioner had become eligible for Medicare coverage on February 1, 2014. BCBSM asserted that, because the Petitioner was Medicare-eligible, its own claim liability was as a secondary provider and, for that reason, the Petitioner's claims would have to be submitted to Medicare before BCBSM would process the claims. BCBSM began to recover from the providers the amounts it had paid for the Petitioner's medical care.

The Petitioner's father appealed the payment recall through BCBSM's internal grievance process. At the conclusion of that process, BCBSM issued its final adverse determination dated December 19, 2014, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Did BCBSM correctly deny coverage as primary insurer for the Petitioner's medical care?

IV. ANALYSIS

BCBSM's Argument

In its final adverse determination, BCBSM's representative wrote to the Petitioner's father:

Your son is covered under the *Blue Cross Premier Gold Benefits Certificate*. In **Section 1: Information About Your Contract** (page 2) the *Certificate* explains the following:

Note to persons who become eligible for Medicare coverage after enrolling in this certificate:

This certificate is not a Medicare supplemental certificate. It is not intended to fill the gaps in Medicare coverage and it may duplicate some Medicare benefits. If you are eligible for Medicare, review the Medicare supplemental buyer's guide available from BCBSM and consider switching your coverage to Medicare supplemental. Be sure you understand what this certificate

covers, what it does not cover, and whether it duplicates coverage you have under Medicare.

If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this certificate.

In this case, Medicare is your son's primary carrier as of February 1, 2014. As mentioned above, once a member becomes eligible for Medicare coverage, BCBSM will not pay for services covered by Medicare. Therefore, your son's providers should be submitting claims to Medicare first for primary reimbursement and then submitting them to BCBSM for secondary consideration. Thus recovery of BCBSM's primary payment of the claims in question is appropriate.

In your appeal request you referenced the Coordination of Benefits Act, Act 64 of 1984 and indicated that under that Act your son's Medicare coverage is supplemental to his Premier Gold coverage. However, this Act does not apply to the current individual health care policy your son is enrolled in. The Coordination of Benefits Act, Act 64 of 1984 applies to group health care coverage. Thus this document is not applicable in [your son's] case.

I understand that the charges referenced in the chart enclosed may be overwhelming. However, as mentioned above BCBSM does not pay for services that are covered under Medicare if the member is a Medicare eligible. Your son's primary health carrier is Medicare and all claims must be submitted to Medicare before BCBSM can consider them for secondary reimbursement. Your son's providers should have received vouchers instructing them to submit your son's claims to Medicare. Once the providers have received a payment determination from Medicare, they can then submit claims to BCBSM for secondary payment consideration.

Petitioner's Argument

The Petitioner's father asserts that the BCBSM policy is his son's primary health benefit plan and Medicare is the secondary plan. The Petitioner's father also asserts that his son is not eligible for Medicare "as evidenced by my social security number on his card." The Petitioner's father states that BCBSM failed, without explanation, to process his appeal on an expedited basis (within 72 hours) as required. Finally, the Petitioner's father argues that BCBSM was required to process his son's claims in accordance with the Michigan "coordination of benefits act" (MCL 550.251, *et seq.*) which requires that the BCBSM coverage be the primary benefit plan for his son.

In a February 20, 2015 letter submitted for this review, the Petitioner's father wrote:

BCBSM's position is waive the Coordination of Benefits section of the policy, collect and retain premiums, and to absolve itself from all liability from claims incurred by my son as of 2/1/14.

My position is that I contracted with BCBSM in December of 2013 for Premier Gold Coverage for one year (all of 2014). My son being included under my Medicare coverage (Exhibit B) at 2/1/2014 did not constitute a "qualifying event" as stipulated by the contract page 8 attached hereto as Exhibit B(1) The policy holder is prevented from changing unless there is a "qualifying event".

Additionally, my position is that my disabled child is eligible for coverage until he turns 26, as stipulated by the contract page 3 attached hereto as Exhibit C. He does not have any work history and miraculously attends college under enormous weight on his mind caused by the arrogant and condescending actions of BCBSM employees.

BCBSM continues to assess premium payments from 2/1/14 to the present while simultaneously clawing back all benefits paid from 2/1/14 to 12/31/14, without fear of violating any fiduciary guidelines established to protect policy holders. BCBSM will continue on this track until the Director orders the reinstatement of all benefits retroactively to 2/1/14.

The basis for the Director's order is that The Coordination of Benefits section of my son's policy was approved by the Director, and the language is crystal clear regarding the fact that BCBSM is primary. I have circled the specific section from my son's policy on Page 138 (Exhibit D), and attached the full Act with the appropriate section circled in red. [REDACTED] Executive Services, BCBSM expressly states that the Coordination of Benefits Act, Act 64 of 1984 "does not apply to the current individual health care policy your (my) son is enrolled in" (Exhibit A). The identical Coordination of Benefits language appears in the 2015 contract, also attached. On the bottom of the same page "no agent has authority to change this policy or to waive any of its provisions (also underlined in red).

[REDACTED] of BCBSM, and her team reviewed my grievance for 5 weeks (October 31, 2014 to December 5, 2014) and decided their it was such a complicated case that [REDACTED] requested another 14 days to review all options. Taking the high road, paying the claims, and living up to the terms of the contract was not an option. Instead, best course of action was for 'Noelle' to waive the entire Coordination of Benefits section from the policy. No rider, no endorsement. Just [REDACTED] decision after 49 days of review.

The checks and balances for strategic ambiguity is when a Department of Insurance takes a stand to defend a policy holder.

In my opinion, it is of utmost importance that the Director uphold the integrity of the Michigan Department of Insurance (DIFS) by ordering BCBSM to pay all claims due to my son's providers retroactively to 2/1/2014.

Director's Review

The Petitioner's father first argues that BCBSM did not process his complaint according to the time limits applicable to an expedited review. The Director finds this argument to be without merit. The requirements for an expedited review by BCBSM are found on page 180 of the *Premier Gold* certificate:

You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The Petitioner had already received the health care services at issue at the time the request for review was filed. Further, the dispute in this case involves BCBSM's effort to recover payments already made to providers. It does not involve an alleged failure to respond in a timely manner to a request for benefits or payment.

The Petitioner's father next asserts that his son is not eligible for Medicare. This argument is disproved by the Medicare eligibility notice which the Petitioner's father submitted with his request for external review. That notice states that the Petitioner was eligible for Medicare beginning on February 1, 2014. In any case, the Petitioner's father also argues that his son is entitled to Medicare benefits, with Medicare as the secondary provider.

The Petitioner's father argues that the Michigan coordination of benefits act is applicable to this dispute because the *Premium Gold* certificate of coverage, on page 138, states that BCBSM "will coordinate the benefits under this certificate using the rules and definitions contained in Michigan's Coordination of Benefits Act..." The Petitioner's father believes that the Act mandates that BCBSM be the primary insurer. The relevant portion of the Act, section 3(1)(a), provides:

The benefits of a policy or certificate that covers the person on whose expenses the claim is based other than as a dependent shall be determined before the benefits of a policy or certificate that covers the person as a dependent. However, if the person is a medicare beneficiary and as a result of the provisions of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395yy, and 1395bbb to 1395ccc, medicare is secondary to the policy or certificate covering the person as a dependent and primary to the

policy or certificate covering the person as other than a dependent, then the order of benefits is reversed and the policy or certificate covering the person as other than a dependent is secondary and the policy or certificate covering the person as a dependent is primary.

The Act, in section 2, defines policies and certificates as contracts issued “in connection with a group disability benefit plan.” The Petitioner’s *Premium Gold* certificate is an individual policy covering himself and his mother. It is not a group benefit plan. For that reason, the provisions in the act cited by the Petitioner’s father do not apply to his son’s coverage.

As BCBSM noted in its final adverse determination, the *Premium Gold* certificate (section 1, page 2) provides: “If you are Medicare eligible and a service is covered under Medicare, benefits will not be payable under this certificate.”

In this case, BCBSM initially paid the claims as though it was Petitioner’s primary insurer. It was not initially aware of the Petitioner’s Medicare coverage eligibility. When, in August 2014, BCBSM learned of the eligibility it ceased paying claims as the primary insurer and sought to recover the provider payments it had issued in error. BCBSM indicated it would make a determination of its payment liability as the secondary payer once the claims were submitted to Medicare for consideration. In fact, some of the Petitioner’s claims have been filed with Medicare which has paid the claims as the primary insurer.

The Director finds that BCBSM’s recall of the Petitioner’s claims that it paid as primary insurer is consistent with the terms of the Petitioner’s certificate of coverage and Michigan law.

While the Director concludes that BCBSM is the secondary insurer, it does not follow, as Petitioner’s father fears, that the Petitioner will be burdened with paying the providers in full for their services. BCBSM has monitored the status of the claims for the Petitioner’s treatment. Of the 494 claims submitted during the February 9, 2014 to October 15, 2014 period, 132 claims have been resubmitted and paid by Medicare and BCBSM. One hundred and seventy five claims are duplicative and are not obligations of Medicare, BCBSM, or the Petitioner. One hundred and eighty seven claims remain to be submitted to Medicare and then BCBSM for processing.

V. ORDER

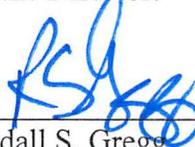
The Director upholds BCBSM’s final adverse determination of December 19, 2014. BCBSM may recall the Petitioner’s claims it paid as primary with BCBSM processing the claims as the secondary insurer after Medicare has completed its processing of the claims.

This is a final decision of an administrative agency. 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. See MCL 550.1915(1). 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:



Randall S. Gregg
Special Deputy Director