

**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. 146941-001-SF**

**State of Michigan, Plan Sponsor**  
**and**  
**Blue Cross Blue Shield of Michigan, Plan Administrator**  
**Respondents**

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**Issued and entered**  
**this 9<sup>th</sup> day of April 2015**  
**by Joseph A. Garcia**  
**Special Deputy Director**

**ORDER**

**I. PROCEDURAL BACKGROUND**

On March 23, 2015, ██████████ (Petitioner) filed a request for external review with the Department of Insurance and Financial Services, appealing a claim denial issued by Blue Cross and Blue Shield of Michigan (BCBSM), the administrator of the Petitioner's health benefit plan which is sponsored by the State of Michigan. The request for external review was filed under Public Act No. 495 of 2006, (Act 495) MCL 550.1951 *et seq.* Act 495 requires the Director to provide external reviews to a person covered by a self-funded health plan that is established or maintained by a state or local unit of government. The Director's review is performed "as though that person were a covered person under the Patient's Right to Independent Review Act." (MCL 550.1952)

On March 30, 2015, after a preliminary review of the information submitted, the Director accepted the Petitioner's request. The Director notified BCBSM of the appeal and asked BCBSM to provide the information used to make its final adverse determination. BCBSM furnished its response on April 7, 2015.

The issue in this external review 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 is ■ years old. His primary health insurance is provided by Medicare. He also receives health care benefits through the retiree plan offered by his former employer. Those benefits are provided under a policy issued by Horizon Blue Cross ■. The Petitioner has a third level of benefits as a dependent under his wife's State of Michigan retiree plan which is administered by BCBSM. The benefits are described in the State of Michigan/BCBSM benefit guide titled *The State Health Plan PPO For Medicare Eligible Retirees*.

On November 5, 2013 the Petitioner received hearing aids from Hearing Health Center, a Michigan provider. The amount charged was \$6,190.00. Medicare does not provide coverage for hearing aids. Horizon Blue Cross, the Petitioner's secondary insurer, considered the claim and approved \$3,250.00. After applying a 20 percent coinsurance charge of \$650.00, paid \$2,600.00 to the provider. The claim was then submitted to BCBSM for payment of the \$650.00 coinsurance charge. BCBSM declined to pay the claim, ruling that Horizon Blue Cross had already paid more than BCBSM's approved amount which was \$2,542.00.

The Petitioner appealed BCBSM's ruling through its internal grievance process. BCBSM issued a final adverse determination on January 23, 2015 affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

## III. ISSUE

Did BCBSM correctly process the Petitioner's claim for hearing aids?

## IV. ANALYSIS

### Respondents' Argument

In its final adverse determination, BCBSM wrote:

You are covered by the State of Michigan. As explained on Page M-79 of its *State Health Plan PPO For Medicare Eligible Retirees*, COB ensures that the level of payment, when added to the benefits payable under another group health plan, will cover up to 100 percent of the eligible expenses as determined between the group health coverage plans. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost of care.

In this case your primary insurer issued payment in the amount of \$2,600.00 to the provider and applied \$650.00 to your coinsurance requirement. However, the BCBSM allowed amount for the service reported is \$2,542.00. Because the

primary insurer's payment is more than the BCBSM allowed amount, secondary payment cannot be approved.

### Petitioner's Argument

In his request for external review, the Petitioner wrote:

I am appealing the January 23, 2015 decision of Blue Cross/Blue Shield of Michigan (BCBSM) regarding reimbursement for hearing aids for the following reasons:

- It appears that Blue Cross/Blue Shield has arbitrarily determined that their allowed amount for hearing aids is their "cost of care". If a person has more than one insurance policy, as I do, BCBSM will not pay any of the cost of the hearing aids, even though the amount paid by the other insurance policy still leaves a substantial amount owed by the patient, because the hearing aid price greatly exceeds the BCBSM "cost of care" allowed amount.
- I have attached copies of the explanation of coordination of benefits from the BCBSM State of Michigan Retirees benefits plan. The explanation is vague, and not a definitive interpretation.
- If BCBSM's interpretation of "cost of care" is a common practice with all insurance companies, this would seem to constitute collusion.
- If hearing aid costs are not covered by BCBSM, as the secondary insurer under coordination of benefits, where a primary insurer has paid the amount that BCBSM considers "cost of care", and the cost of the hearing aids greatly exceeds the amount paid by the primary insurer, then that fact should be plainly stated in the retiree benefits handbook.

### Director's Review

This appeal involves the coordination of benefits between two health benefit plans, Horizon Blue Cross and BCBSM. Because Horizon's plan insures the Petitioner directly as a retiree while the BCBSM plan covers the Petitioner as a dependent, the Horizon plan must process the claim first. Any amount unpaid after Horizon has processed the claim may then be submitted to BCBSM.

The BCBSM benefit guide includes this provision regarding coordination of benefits:

COB [coordination of benefits] ensures that the level of payment, when add to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the group health care plans....COB also

makes sure that the combined payments of all coverage will not exceed the approved cost of care.

The benefit guide defines approved amount as:

the BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Under its benefit guide, BCBSM will pay only up to its approved amount for a covered benefit minus the amount paid by any other carrier. In this case, BCBSM's approved amount for the hearing aids was \$2,542.00. However, Horizon Blue Cross paid \$2,600.00 for the hearing aids. This payment exceeded BCBSM's approved amount of \$2,542.00. For that reason, under the coordination of benefits provision in BCBSM's benefit guide, BCBSM is not obligated to issue payments for the hearing aids.

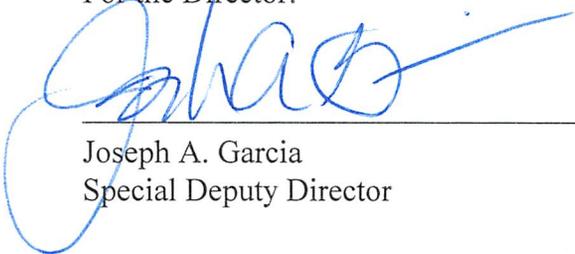
#### V. ORDER

The Director upholds BCBSM's January 23, 2015 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 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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Joseph A. Garcia  
Special Deputy Director