

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. 147028-001

Blue Cross Blue Shield of Michigan,
Respondent.

Issued and entered
this 17th day of April 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On March 27, 2015, ██████████ (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.* On April 3, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits under 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 April 9, 2015.

This case can be resolved by applying the terms of the Petitioner's coverage; it does not require a medical opinion from an independent review organization. See MCL 550.1911(7).

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Keep Fit and Member Edge Individual Market Certificate*¹ (the certificate). The certificate is amended by *Rider IOC \$10,000/\$20,000-I, \$13,500/\$27,000-O, \$13,500/ \$27,000 OOPM Inpatient and Outpatient Cost-Sharing Requirements* (the rider).

¹ BCBSM form no. 351D, approved 10/12.

From January 6 through October 14, 2014, the Petitioner received various outpatient medical services. BCBSM applied \$13,214.04 of its approved amount to the Petitioner's \$13,500.00 annual deductible for outpatient services from in-network (panel) providers and also applied \$275.00 in copayments. This left the Petitioner responsible to the providers for \$13,489.04.²

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 March 10, 2015, upholding its payment decisions. The Petitioner now seeks a review of that final adverse determination from the Director.

III. ISSUE

Did BCBSM correctly process the claims for the outpatient services the Petitioner received?

IV. ANALYSIS

Petitioner's Argument

On the request for external review form the Petitioner wrote:

My problem with BCBS is that I trusted verbal agreement by their agent and did not have a written paper with values and [numbers]. I wrote a plea to them and I am enclosing my letter, with their reply, and my forwarding letter to them as I feel I was wronged. . . .

In her letter dated March 18, 2015 to BCBSM, the Petitioner further explained that she misunderstood her coverage with BCBSM, particularly the deductible for outpatient services:

. . . I was not contesting your accounts, because they were in accordance with what you considered was my contract.

What I am contesting is:

- 1) There was NOT a written, signed agreement or contract, that would put everyone's responsibilities in focus and from the start (and I blame myself and my ignorant trust in the agent and BCBS).
- 2) I was in the assumption that the plan I chose (verbally) had a . . . \$3,500 outpatient [deductible] and not like you mentioned in your letter.
- 3) Your agent and your representatives answering my numerous calls were confirming my understanding of those numbers. Up to a period . . . where the values shifted to a higher deductible and the tune changed when the bills started to flow. Even your agent was surprised by the hype. But when he called your offices, he was told that the outpatient ded[uctible] was \$13,500. . . .

² BCBSM paid the providers \$14,247.07 for these services.

- 4) My plea was for you to rectify the results of not having a written and signed agreement, as numbers might differ verbally.

The Petitioner wants BCBSM to honor the deductible amount she says she was told it would be for outpatient services.

BCBSM's Argument

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

After a thorough review, I confirmed that the copayment and in-network outpatient deductible amounts were applied correctly to your claims. You are responsible for copayments totaling \$275.00 for medical visits and the in-network outpatient deductible accumulations totaling \$13,214.04. I've enclosed a chart to detail the claims.

At the time of service, you were covered under the *Keep Fit and Member Edge Individual Market Certificate. Section 2: What You Must Pay*, Page 2.1 explains that all benefits are subject to cost-share (deductibles, coinsurance, and copayment) requirements. Page 2.4 explains that you are required to pay a copayment for covered services. Your copayment requirements include \$40 visit for each of the two physician office visits that are covered under the certificate, \$40 per visit for each chemotherapy follow-up visit; and \$75 per visit for urgent care services, including those in a physician's office.

Rider IOC \$10,000/\$20,000-I, \$13,500/\$27,000-O, \$13,500/\$27,000 OOPM Inpatient and Outpatient Cost-Sharing Requirements amends the certificate and increases deductible requirements for outpatient services, including all facility and professional benefit obtained from panel providers, to \$13,500 for a one-person contract. Because you had not met your annual deductible requirement, the deductible amounts in question were correctly applied to your claims.

In your letter and during your managerial-level conference, you explained that you were under the assumption that your policy had a \$3,500 in-patient deductible and a \$6,000 outpatient deductible based on information given to you by a sales agent.

Please know that your complaint regarding your enrollment experience has been reported to appropriate staff for investigation, and will use this information that you provided to better our services to our members.

Nonetheless, with regard to your appeal, we must uphold our position. While we understand your position, we are unable to waive cost-sharing responsibilities. We are bound by the provisions of coverage.

Director's Review

According to information provided by BCBSM, the Petitioner received certain covered outpatient medical services from multiple providers from January 6 to October 14, 2014; those services were subject to the \$13,500.00 annual deductible for outpatient services. Therefore, BCBSM applied

\$13,214.04 to the annual outpatient deductible. The Petitioner does not dispute BCBSM's numbers and concedes that BCBSM processed the claims under the terms of her actual coverage.

The Petitioner's real complaint is that she was lead to believe that the deductible for outpatient services under her coverage was only \$3,500.00, not \$13,500.00. She says she did not discover the mistake until she started to receive bills. Unfortunately, that is not the kind of issue that can be resolved under the Patient's Right to Independent Review Act (PRIRA).

Under PRIRA, the Director's role is to determine if BCBSM properly administered benefits under the terms of the certificate in effect and Michigan law. Whatever the source of the misinformation, PRIRA does not give the Director the authority to reform the terms of an actual insurance contract based on misstatements or misrepresentations made by an insurer's employees or agents.

The rider established a \$13,500.00 annual deductible outpatient services from panel providers. There is no dispute that the Petitioner had not met this deductible when her services were rendered. Therefore, the Director finds that BCBSM acted in accord with the terms of the certificate and rider when it applied \$13,214.04 of its approved amount toward the unmet deductible.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 10, 2015.

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 Michigan 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