

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. 147164-001-SF

State of Michigan, Plan Sponsor,

and

Blue Cross Blue Shield of Michigan, Plan Administrator,

Respondents.

Issued and entered
this 27th day of April 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 3, 2015, ██████████, authorized representative of ██████████ (Petitioner), filed a request with the Director of Insurance and Financial Services for an external review under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq.* On April 10, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a plan sponsored by the State of Michigan, a self-funded governmental health plan as defined in Act 495. Blue Cross Blue Shield of Michigan (BCBSM) administers the plan. 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 21, 2015.

Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Director to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

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

From September 17, 2012, through July 21, 2014, the Petitioner received services from multiple providers. Medicare, the Petitioner's primary coverage, denied the claims for those services because the Petitioner was not enrolled in Part B. When the claims were submitted to BCBSM, it paid only the supplemental portion of the claims, leaving the Petitioner responsible for the Medicare portion (\$15,226.56).

The Petitioner appealed BCBSM's decision through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 13, 2015, affirming its decision. The Petitioner now seeks a review of that adverse determination from the Director.

III. ISSUE

Was BCBSM required to pay more for the care provided from September 17, 2012, through July 21, 2014?

IV. ANALYSIS

The Petitioner became eligible for Medicare in 2008 because of a disability. On July 1, 2008, he enrolled in Medicare Part A (hospital coverage) and Part B (medical coverage); he subsequently dropped the Part B coverage on March 31, 2009.¹ Even though he was enrolled in Medicare, the Petitioner continued to have primary coverage through the State of Michigan plan as a dependent of his spouse until she retired as employee of the state in November 2010.

When his spouse retired, Medicare became the Petitioner's primary coverage. His benefits through the State of Michigan plan, now his secondary coverage, were defined in a booklet called *The State Health Plan PPO For Medicare-Eligible Retirees* (the benefit booklet).

From September 17, 2012, through July 21, 2014, the Petitioner received outpatient services (Part B benefits) from multiple providers.² When BCBSM declined to pay more than the amount it was obligated to pay as the secondary coverage, the Petitioner appealed. At the conclusion of its grievance process, BCBSM explained its decision to the Petitioner's spouse in its final adverse determination:

After review, the payment levels are maintained because [the Petitioner] was not enrolled in Medicare Part B at the time of these services. Your plan does not cover the amount Part B would have paid. I have included a chart that shows the dates, provider names, and amounts that are owed for claims affected by Medicare Part B sanctions. You remain

¹ He did not re-enroll in Part B until August 1, 2014.

² BCBSM apparently paid some of the claims in error and then recalled those payments from the providers.

liable for the total amount of \$15,226.56 for the date range of September 17, 2012 through July 21, 2014; the amount Medicare Part B would have covered. Let me explain further.

* * *

Our records indicate that [the Petitioner] enrolled in Medicare Parts A and B on July 1, 2008. [The Petitioner] then cancelled Medicare Part B on March 31, 2009. He did not re-enroll in Medicare Part B until August 1, 2014. Between July 1, 2008 [*sic*] and August 1, 2014, [he] did not have Medicare Part B coverage.

What this means is that for claims in which Medicare Part B would have applied, the State Health Plan pays the claim as if the member has Medicare Part B. Your coverage plan does not pay the amount Medicare Part B would have paid, but leaves the member liable for those amounts.

I understand your concerns regarding these services. While I regret you may have been advised to follow this course of action by a Medicare representative, we must process claims by the terms of your contract. . . .

The Petitioner's argument was advanced by his authorized representative in a letter to BCBSM dated January 8, 2015, that was included with the external review request:

We are disputing the decision of [BCBSM] denying his medical bills and requesting refunds from his physicians for a two year period of time because [the Petitioner] opted out of Medicare Part B coverage. [The Petitioner] was told by Medicare that he did not have to have Part B because he was covered under his spouse's medical insurance through her employment with the State of Michigan. Her husband has required extensive medical treatment requiring multiple hospitalizations for colon and had gall bladder surgery. We are appealing this denial. [The Petitioner's wife] has never received a letter of denial but was told over the telephone her claim was denied.

The benefit booklet (pp. 7-8) explains how the Petitioner's coverage works when the State of Michigan plan becomes secondary:

Your health coverage [*with the State of Michigan plan*] continues when you or your covered dependents become eligible for Medicare by providing you Medicare Supplemental benefits. These benefits supplement Medicare so that you enjoy the same covered services as non-Medicare members.

You become eligible for Medicare coverage at age 65. If you are disabled or if you have end stage renal disease, you will be eligible for Medicare at an earlier age. This means that the health plan will only pay the supplemental portion of your health services. To limit your out-of-pocket expenses, you should enroll in both Medicare Part A and Part B when you first become eligible. Regardless of your age, you should enroll in Part A and Part B if you or your dependents are recognized by Social Security as being disabled or diagnosed with end stage renal disease.

If you do not enroll in both Part A and Part B of Medicare when eligible, your health plan coverage will be adjusted as if Medicare coverage was in place. In this case, the plan will not reimburse that portion of an expense normally covered by Medicare. This may result in limited or no payment, or retroactive adjustment to claims.

* * *

. . . To receive Medicare Supplemental coverage through the State Health Plan PPO, you must select Medicare Part A (hospital insurance) and Part B (medical insurance). Your supplemental benefits expand your Medicare coverage so that you enjoy the same covered services as before you enrolled in Medicare. Your supplemental plan also pays the Medicare annual deductible and Medicare coinsurance (Medicare's term for copay) amounts for services covered under the State Health Plan PPO.

* * *

. . . If you are eligible for Medicare coverage but decline it, then you will be responsible for paying the portion of health care costs that Medicare would normally pay. [Underlining added]

There is no dispute that the Petitioner was not enrolled for Medicare Part B benefits from September 17, 2012, through July 21, 2014, the period in which he received extensive outpatient care. Therefore, the Director concludes and finds that BCBSM was correct when it processed the claims for those services and paid only the supplemental benefits the plan was required to cover under the terms of the benefit booklet.

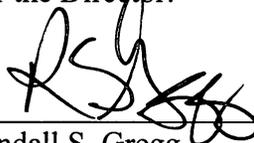
V. ORDER

The Director upholds BCBSM's February 13, 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:



Randall S. Gregg
Special Deputy Director