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. 147547-001**

Blue Cross Blue Shield of Michigan,

Respondent.

Issued and entered
this 18th day of May 2015
by Randall S. Gregg
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On April 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 May 4, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner receives health care benefits through a small group 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 May 7, 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

On December, 3, 2014, the Petitioner had outpatient surgery (total knee arthroplasty) and related care (radiology, hospital services). All the services were obtained from panel providers, i.e., providers who had contracted to provide services under the Petitioner's plan and accept BCBSM's approved amount as payment in full for covered services. BCBSM covered the surgery but required the Petitioner to pay $2,350.00.00 in coinsurance.

The Petitioner appealed BCBSM's benefit determination through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated March 31, 2015, upholding its decision. The Petitioner now seeks a review of that final adverse determination from the Director.

III. Issue

Did BCBSM correctly process the claims related to the Petitioner's surgery on December 3, 2014?

IV. Analysis

From January 1 through November 30, 2014, the Petitioner's health care benefits were defined in BCBSM's *Simply Blue Health Savings Account Without Prescription Drug Coverage Group Benefits Certificate.*[1]

Under that coverage, there was a $3,000.00 annual deductible and a $1,000.00 annual coinsurance maximum for services from panel providers. BCBSM says the Petitioner had met both the deductible and the coinsurance maximum by March 5, 2014, i.e., he had paid out-of-pocket a total of $4,000.00.

Beginning on December 1, 2014, the Petitioner's health care coverage changed. On and after that date his benefits were defined in BCBSM's *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG.*[2] That certificate is amended by *Rider SB-HSA-$3,000 SG Simply Blue HSA Cost-Sharing Requirements* (the rider) which increased the cost-sharing requirements in the certificate.

The Petitioner had his knee surgery on December 3, 2014. When the claims for that surgery were processed, he learned he would be responsible for $2,350.00 in coinsurance. The Petitioner believes he should have no out-of-pocket expense for the surgery because he was told he had already reached his annual out-of-pocket maximum by that date. In a February 15, 2015, letter included with his external review request, the Petitioner explained:

> Just to make sure there was no confusion in regards to my Dec 3rd 2014 scheduled surgery I phoned BCBS on Friday, 11/21/ 2013 at 9:23 AM. I explained what my upcoming surgery was and when it was scheduled. I was advised (by an unknown female) that I was fine and there would be no out of pocket costs to me because those had been met with my March [*2014*] surgery. It was reiterated to me that I was good up to 12/31/2014 as far as out of pocket expenses.

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1 BCBSM form no. 665C, approved 10/12. The certificate was amended by three riders: *Rider SB-HSA-C 20%-P 40%-NP; Rider SB-HAS-CM 1000/2000-P, 2000/4000-NP Simply Blue HSA Coinsurance Maximum; and Rider SB-HSA-D 3000/6000-P, 6000/12,000-NP.*

2 BCBSM form no. 913F, federal approval 9/2013, state approval 08/14.

> I then called my agent . . . to confirm the same thing. He also guaranteed me out of pocket expenses had been met and I was good to go. With that information in hand I proceeded to have said surgery. I am now getting bills and phone calls from [providers] because it seems BCBS changed my policy without my knowledge or consent. This change went into effect on 12/1/2014.
>
> Had I had knowledge this was the case I would have either bumped up the surgery by 3 days or cancelled it. I had funds budgeted to cover my March Surgery but am at a complete loss as to where I will get funds to cover any additional out of pocket expenses.
>
> I strongly disagree with the way BCBS has handled this and urge them to immediately pay the outstanding balances I am being billed.

BCBSM's "Case Documentation Record" confirms the Petitioner's assertion. The BCBSM representative who handled the Petitioner's grievance noted on March 23, 2015:

> Reviewed member phone call of 11.21.14: . . . Member asked if his coverage was going to be affected on 12.01.14, and specifically asked if his current cost-share amounts would remain satisfied through the end of the calendar year, and was advised that his cost-share had been met through 12.31.14.

Nevertheless, BCBSM processed the surgery claims under the terms of the coverage that went into effect on December 1, 2014. Under that coverage, the deductible for panel services remained at $3,000.00 but the coinsurance rate increased from 20% to 30%, and an annual out-of-pocket maximum of $6,350.00 was established. BCBSM explained its decision to the Petitioner in its final adverse determination:

> . . . [W]hen your benefit package changed on December 1, 2014, you became responsible for the $6,350 in-network out-of-pocket maximum required under the *Simply Blue HSA Group Benefits Certificate with Prescription Drugs SG*. You were credited with the $4,000 you had already expended in deductible and coinsurance payments under your previous benefit package. Your outstanding cost-share requirement was $2,350, which was applied to your coinsurance following your surgery on December 3, 2014. The charges from that date of service satisfied your $6,350 out-of-pocket maximum. After conducting a full review of all charges, I have determined that your cost-share accumulations were calculated correctly according to your contract during all phases of your coverage in 2014.
>
> BCBSM's Customer Service Representatives make every effort to provide our members and their providers with accurate benefit information in a courteous and professional manner. While the information provided was accurate according to your coverage at the time of your call, I sincerely regret that your conversation with our agent may have been misleading in this instance. I do understand that

> you relied on the information you received in deciding to proceed with your surgery. However, as a Grievance and Appeals Coordinator for BCBSM, it is my responsibility to ensure that the claims were processed according to the terms of your coverage, and I am unable to make an exception on your behalf.

The Petitioner got credit for the $4,000.00 he paid out-of-pocket under the previous coverage, so he still had $2,350.00 remaining before he reached the new out-of-pocket maximum for panel services in 2014. Consequently, when BCBSM processed the surgery claims, those claims were subject to 30% coinsurance until the Petitioner reached the $6,350.00 maximum.

The Petitioner argues that BCBSM should cover his December 2014 surgery with no cost sharing on his part because he was given wrong information and relied on that misinformation to make a decision about the surgery.

Unfortunately, the Director does not have the authority under the Patient's Right to Independent Review Act to alter or amend the terms of coverage because of misinformation given out by BCBSM or its representatives. The Director can only determine if BCBSM correctly administered benefits according to the terms and conditions of the applicable certificate and riders. Here the Director concludes and finds that BCBSM correctly processed the Petitioner's claims under the provisions in effect as of December 1, 2014.

V. ORDER

The Director upholds BCBSM's final adverse determination of March 31, 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. 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.

Patrick M. McPharlin
Director

For the Director:

Randall S. Gregg
Special Deputy Director